Maricopa County

PREFERRED PROVIDER MEDICAL
BENEFITS

EFFECTIVE DATE: January 1, 2006

CN005
3205496

This document printed in March, 2006 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

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Home Office: Bloomfield, Connecticut
Mailing Address: Hartford, Connecticut 06152

CONNECTICUT GENERAL LIFE INSURANCE COMPANY
a CIGNA company (called CG) certifies that it insures certain Employees for the benefits provided by the following policy(s):

POLICYHOLDER: Maricopa County

GROUP POLICY(S) — COVERAGE
3205496 – HSAI, HSAF PREFERRED PROVIDER MEDICAL BENEFITS

EFFECTIVE DATE: January 1, 2006

NOTICE
Any insurance benefits in this certificate will apply to an Employee only if: a) he has elected that benefit; and b) he has a "Final Confirmation Letter," with his name, which shows his election of that benefit.

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.
This certificate takes the place of any other issued to you on a prior date which described the insurance.

Susan L. Cooper
Corporate Secretary

Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

The Schedule

The Schedule is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.

Special Plan Provisions

When you select a Participating Provider, this Plan pays a greater share of the costs than if you select a non-Participating Provider. Participating Providers include Physicians, Hospitals and Other Health Care Professionals and Other Health Care Facilities. Consult your Physician Guide for a list of Participating Providers in your area. Participating Providers are committed to providing you and your Dependents appropriate care while lowering medical costs.

Services Available in Conjunction With Your Medical Plan

The following pages describe helpful services available in conjunction with your medical plan. You can access these services by calling the toll-free number shown on the back of your ID card

FPINTRO4V1

CIGNA'S Toll-Free Care Line

CIGNA's toll-free care line allows you to talk to a health care professional during normal business hours, Monday through Friday, simply by calling the toll-free number shown on your ID card.

CIGNA's toll-free care line personnel can provide you with the names of Participating Providers. If you or your Dependents need medical care, you may consult your Physician Guide which lists the Participating Providers in your area or call CIGNA's toll-free number for assistance. If you or your Dependents need medical care while away from home, you may have access to a national network of Participating Providers through CIGNA's Away-From-Home Care feature. Call CIGNA's toll-free care line for the names of Participating Providers in other network areas. Whether you obtain the name of a Participating Provider from your Physician Guide or through the care line, it is recommended that prior to making an appointment you call the provider to confirm that he or she is a current participant in the Preferred Provider Program.

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Case Management

Case Management is a service provided through a Review Organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a Hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending Physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your Dependent. In addition, Case Managers are supported by a panel of Physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending Physician remains responsible for the actual medical care.

- You, your dependent or an attending Physician can request Case Management services by calling the toll-free number shown on your ID card during normal business hours, Monday through Friday. In addition, your employer, a claim office or a utilization review program (see the PAC/CSR section of your certificate) may refer an individual for Case Management.
- The Review Organization assesses each case to determine whether Case Management is appropriate.
- You or your Dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.

FPCM6 M

- Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.
- The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).
- The Case Manager also acts as a liaison between the insurer, the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).

- Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

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Additional Programs

CG may, from time to time, offer or arrange for various entities to offer discounts, benefits or other consideration to Employees for the purpose of promoting their general health and well being. Contact CG for details of these programs.

GM6000 PRM1

Important Notices

Arizona
Important Notice

This notice is to advise you that you can obtain a replacement Appeals Process Information Packet by calling the Customer Service Department at the telephone number listed on your identification card for "Claim Questions/Eligibility Verification" or for "Member Services" or by calling 1-800-244-6224.

The Information Packet includes a description and explanation of the appeal process for CG.

GM6000 NOT102

Arizona
Provider Lien Notice

Arizona law entitles health care providers to assert a lien for their customary charges for the care and treatment of an injured person upon any and all claims of liability or indemnity, except health insurance. If you are injured and have a claim against a non-health liability insurer (such as automobile or homeowner insurance) or any other payor source for injuries sustained, your health care provider may assert a lien against available proceeds from any such insurer or payor in an amount equal to the difference between the sum, if any, payable to the health care provider under this Plan and the health care provider's full billed charges.

GM6000 NOT109

Effect Of Section 125 Regulations On This Plan

Your Employer has chosen to administer this Plan in accordance with Section 125 Regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits. Otherwise you will receive your taxable earnings as cash (salary).

Provisions in this certificate which allow for enrollment or coverage changes not consistent with Section 125 Regulations are superseded by this section.

Coverage Elections

Per Section 125 Regulations, you are generally allowed to enroll for or change coverage only before each benefit period. However, exceptions are allowed if you enroll for or change coverage within 30 days of the following:

- the date you meet Special Enrollment criteria per federal requirements as described in the Section entitled “Eligibility – Effective Date/Exception to Late Entrant Definition”; or
- the date you meet criteria shown in the section entitled “Change of Status.”

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Change in Status

A change in status is defined as:

- change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
- change in number of dependents due to birth, adoption, placement for adoption or death of a dependent;
- change in employment status of Employee, spouse or dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under Family and Medical Leave Act (FMLA) or change in worksite;
- changes in employment status of Employee, spouse or dependent resulting in eligibility or ineligibility for coverage;
- change in residence of Employee, spouse or dependent; and
- changes which cause a dependent to become eligible or ineligible for coverage.

Any changes in coverage must pertain directly to the change in status.

Court Order

A change in coverage due to and consistent with a court order of the Employee or other person to cover a Dependent.

Medicare Eligibility/Entitlement

The Employee, spouse or Dependent cancels or reduces coverage due to entitlement to Medicare, or enrolls or increases coverage due to loss of Medicare eligibility.

Change in Cost of Coverage

If the cost of benefits increases or decreases during a benefit period, your Employer may in accordance with plan terms automatically change your elective contribution.

When the change in cost is significant, you may either increase your contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit option is added, you may change your election to the new benefit option.

Changes in Coverage of Spouse or Dependent Under Another Employer's Plan

You may make a coverage election change if the plan of your spouse or Dependent: (a) incurs a change such as adding or deleting a benefit option; (b) allows election changes due to Special Enrollment, Change in Status, Court Order or Medicare Eligibility/Entitlement; or (c) this Plan and the other plan have different periods of coverage.

GM6000 SCT125V2

How To File Your Claim

The prompt filing of any required claim form will result in faster payment of your claim.

You may get the required claim forms from your Benefit Plan Administrator. All fully completed claim forms and bills should be sent directly to your servicing CG Claim Office.

Depending on your Group Insurance Plan benefits, file your claim forms as described below.

Hospital Confinement

If possible, get your Group Medical Insurance claim form before you are admitted to the Hospital. This form will make your admission easier and any cash deposit usually required will be waived.

If you have a Benefit Identification Card, present it at the admission office at the time of your admission. The card tells the Hospital to send its bills directly to CG.

Doctor's Bills and Other Medical Expenses

The first Medical Claim should be filed as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. If you have any additional bills after the first treatment, file them periodically.

CLAIM REMINDERS

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT NUMBER WHEN YOU FILE CG'S CLAIM FORMS, OR WHEN YOU CALL YOUR CG CLAIM OFFICE.

  YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

  YOUR ACCOUNT NUMBER IS THE 7-DIGIT POLICY NUMBER SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
- PROMPT FILING OF ANY REQUIRED CLAIM FORMS RESULTS IN FASTER PAYMENT OF YOUR CLAIMS.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

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Accident and Health Provisions

Claims

Notice of Claim

Written notice of claim must be given to CG within 30 days after the occurrence or start of the loss on which claim is based. If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible.

Claim Forms

When CG receives the notice of claim, it will give to the claimant, or to the Policyholder for the claimant, the claim forms which it uses for filing proof of loss. If the claimant does not get these claim forms within 15 days after CG receives notice of claim, he will be considered to meet the proof of loss requirements of the policy if he submits written proof of loss within 90 days after the date of loss. This proof must describe the occurrence, character and extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be given to CG within 90 days after the date of the loss for which claim is made. If written proof of loss is not given in that time, the claim will not be invalidated or reduced if it is shown that written proof of loss was given as soon as was reasonably possible.

Physical Examination

CG, at its own expense, will have the right to examine any person for whom claim is pending as often as it may reasonably require.

Legal Actions

Where CG has followed the terms of the policy, no action at law or in equity will be brought to recover on the policy until at least 60 days after proof of loss has been filed with CG. No action will be brought at all unless brought within 3 years after the time within which proof of loss is required.

GM6000 CLA43V6

Eligibility - Effective Date

You will become eligible for insurance on the day you complete the waiting period if:

- you are in a Class of Eligible Employees; and
- you normally work at least 40 hours per pay period..

If you were previously insured and your insurance ceased, you must satisfy the New Employee Group Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you will be eligible on the first of the month following your date of re-hire if you again become a member of a Class of Eligible Employees after your insurance ceased.

Initial Employee Group: You are in the Initial Employee Group if you are employed in a class of employees on the date that class of employees becomes a Class of Eligible Employees as determined by your Employer.

New Employee Group: You are in the New Employee Group if you are not in the Initial Employee Group.

Waiting Period

Initial Employee Group: First day of the month following the date of hire.

New Employee Group: First day of the month following the date of hire.

Classes of Eligible Employees

Each Employee as reported to the insurance company by your Employer.

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Employee Insurance

This plan is offered to you as an Employee. To be insured, you will have to pay part of the cost.

Effective Date of Your Insurance

You will become insured on the date you elect the insurance by enrolling via the online tool, thus authorizing a payroll deduction, but no earlier than the date you become eligible. If you are a Late Entrant, your insurance will not become effective until CG agrees to insure you. You will not be denied enrollment for Medical Insurance due to your health status.

You will become insured on your first day of eligibility, following your election, if you are in Active Service on that date, or if you are not in Active Service on that date due to your health status. However, you will not be insured for any loss of life, dismemberment or loss of income coverage until you are in Active Service.

Late Entrant - Employee

You are a Late Entrant if:

- you elect the insurance more than 31 days after you become eligible; or
- you again elect it after you cancel your payroll deduction.

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ELI7V125 M

Exception to Late Entrant Definition

You will not be considered a Late Entrant when enrolling outside a designated enrollment period if: you had existing coverage, and you certified in writing, if applicable, that you declined coverage due to such coverage; you lost coverage under the prior plan due to your termination of employment or eligibility; the termination of the prior plan's coverage; legal separation; the death of the spouse; divorce; or termination of Employer contributions toward the coverage; if such prior coverage was continuation coverage and the continuation period has been exhausted and you enroll for this coverage within 31 days after losing or exhausting prior coverage; or if you are a Dependent spouse or minor child enrolled due to a court order, and you are enrolling within 31 days after the court order is issued.

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption, you may enroll your eligible Dependents and yourself, if you are not already enrolled, within 31 days of such event. Coverage will be effective, on the date of marriage, birth, adoption, or placement for adoption.

Any applicable Pre-existing Condition limitation will apply to you and your Dependents upon enrollment, reduced by prior Creditable Coverage, but will not be extended as for a Late Entrant.

Pre-Existing Condition Limitation for Late Entrant

For plans which include a Pre-existing Condition limitation, the one-year waiting period before coverage begins for such conditions, will be increased to 18 months for a Late Entrant.

For plans which do not include a Pre-existing Condition limitation, you may be required to wait until the next plan enrollment period to enroll for coverage under the plan, if you are a Late Entrant.

For plans which do not standardly include a Pre-existing Condition limitation and which do not include an annual open enrollment period, a Pre-existing condition limitation of 18 months will apply for a Late Entrant only.

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Dependent Insurance

For your Dependents to be insured, you will have to pay part of the cost of Dependent Insurance.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by enrolling via the online tool, thus authorizing a payroll deduction, but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

If you are a Late Entrant for Dependent Insurance, the insurance for each of your Dependents will not become effective until CG agrees to insure that Dependent. Your Dependent will not be denied enrollment for Medical Insurance due to health status.

Your Dependents will be insured only if you are insured.

Late Entrant - Dependent

You are a Late Entrant for Dependent Insurance if:

- you elect that insurance more than 31 days after you become eligible for it; or
- you again elect it after you cancel your payroll deduction.

Exception for Newborns

Any Dependent child born while you are insured for Medical Insurance will become insured for Medical Insurance on the date of his birth if you elect Dependent Medical Insurance no later than 31 days after his birth. If you do not elect to insure your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

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PREFERRED PROVIDER MEDICAL BENEFITS

The Schedule

For You and Your Dependents

Preferred Provider Medical Benefits provide coverage for care In-Network and Out-of-Network. To receive Preferred Provider Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance.

If you are unable to locate an In-Network Provider in your area who can provide you with a service or supply that is covered under this plan, you must call the number on the back of your I.D. card to obtain authorization for Out-of-Network Provider coverage. If you obtain authorization for services provided by an Out-of-Network Provider, benefits for those services will be covered at the In-Network benefit level.

Coinsurance
The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the plan.

Copayments/Deductibles
Copayments are expenses to be paid by you or your Dependent for the services received. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from and not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached you and your family need not satisfy any further medical deductible for the rest of that year.

Out of Pocket Expenses
Out-of-Pocket Expenses are Covered Expenses incurred for In-Network and Out-of-Network charges for which no payment is provided because of the coinsurance factor. In addition, charges for Covered Expenses incurred for or in connection with Mental Health and Substance Abuse will accumulate toward the Out-of-Pocket Maximums and benefits for such expenses will be increase. However, charges for Covered Expenses incurred for or in connection with non-compliance penalties or in excess of the Maximum Reimbursable Charge levels will not accumulate toward the Out-of-Pocket Maximums and benefits for such expenses will not be increased.

Accumulation of Plan Deductibles and Out-of-Pocket Maximums
Deductibles and Out-of-Pocket Maximums will accumulate in one direction (e.g. Out-of-Network will accumulate to In-Network). All other plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted.
Note:
Refer to your CIGNA Choice Fund Member Handbook for information about your health fund benefit and how it can help you pay for expenses that may not be covered under this plan.

Contract Year

Contract Year means a twelve month period beginning on each January 1.

Multiple Surgical Reduction
Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon
The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed 20 percent of the surgeon's allowable charge. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)

Co-Surgeon
The maximum amount payable will be limited to charges made by co-surgeons that do not exceed 20 percent of the surgeon's allowable charge plus 20 percent. (For purposes of this limitation, allowable charge means the amount payable to the surgeons prior to any reductions due to coinsurance or deductible amounts.)

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	$ 5,000,000	
Coinsurance Levels	80%	60% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Contract Year Deductible		
Individual Family Maximum	$ 1,100 per person $ 2,200 per family	$ 1,100 per person $ 2,200 per family
Family Maximum Calculation **Collective Deductible:** All family members contribute towards the family deductible. An individual cannot have claims covered under the plan coinsurance until the total family deductible has been satisfied.		
Out-of-Pocket Maximum		
Individual Family Maximum	$ 5,000 per person $ 10,000 per family	$ 5,000 per person $ 10,000 per family
Family Maximum Calculation **Collective Out-of-Pocket Maximum:** All family members contribute towards the family out-of-pocket. An individual cannot have claims covered at 100% until the total family deductible has been satisfied.		
Includes Coinsurance Includes Deductible Includes Copays	Yes No Mental Health and Substance Abuse	Yes Mental Health and Substance Abuse No
Physician's Services		
Primary Care Physician's Office visit	80% after plan deductible	60% after plan deductible
Specialty Care Physician's Office Visits Consultant and Referral Physician's Services **Note: OB/GYN provider is considered a Specialist.**	80% after plan deductible	60% after plan deductible
Surgery Performed In the Physician's Office	80% after plan deductible	60% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Second Opinion Consultations (provided on a voluntary basis)	80% after plan deductible	60% after plan deductible
Allergy Treatment/Injections	80% after plan deductible	60% after plan deductible
Allergy Serum (dispensed by the physician in the office)	80% after plan deductible	60% after plan deductible
Preventive Care Routine Preventive Care Contract Year Maximum through age 2 (including immunizations): Unlimited Contract Year Maximum for ages 3 and above (including immunizations): Unlimited **Note:** X-ray and/or lab services performed and billed by an independent diagnostic facility or outpatient hospital are covered under the plan's x-ray/lab benefit. **Note:** Well-woman OB/GYN visits will be considered a Specialist visit		
Physician's Office Visit	No charge	In-Network coverage only
Immunizations	No charge	In-Network coverage only
Mammograms, PSA, Pap Smear **Note:** Preventive care related services and diagnostic related services are paid at the same level of benefits as other x-ray and lab services, based on place of service.	No charge after plan deductible if billed by an independent diagnostic facility or outpatient hospital. **Note:** The associated wellness exam will be covered at No charge	60% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Inpatient Hospital - Facility Services	80% after plan deductible	60% after plan deductible
Semi-Private Room and Board	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Private Room	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Special Care Units (ICU/CCU)	Limited to the negotiated rate	Limited to the ICU/CCU daily room rate
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room. **Note:** Non-surgical treatment procedures are not subject to the facility copay. **Note:** See page titled Outpatient Certification Requirements –Out-of-Network.	80% after plan deductible	60% after plan deductible
Inpatient Hospital Physician's Visits/Consultations	80% after plan deductible	60% after plan deductible
Inpatient Hospital Professional Services Surgeon Radiologist Pathologist Anesthesiologist	80% after plan deductible	60% after plan deductible
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist	80% after plan deductible	60% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Emergency and Urgent Care Services		
Physician's Office Visit	80% after plan deductible	80% after plan deductible (except if not a true emergency, then 60% after plan deductible)
Hospital Emergency Room	80% after plan deductible	80% after plan deductible (except if not a true emergency, then 60% after plan deductible)
Outpatient Professional services (radiology, pathology and ER Physician)	80% after plan deductible	80% after plan deductible (except if not a true emergency, then 60% after plan deductible)
Urgent Care Facility or Outpatient Facility	80% after plan deductible	80% after plan deductible (except if not a true emergency, then 60% after plan deductible)
X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)	80% after plan deductible	80% after plan deductible (except if not a true emergency, then 60% after plan deductible)
Independent x-ray and/or Lab Facility in conjunction with an ER visit	80% after plan deductible	80% after plan deductible (except if not a true emergency, then 60% after plan deductible)
Ambulance	80% after plan deductible *waived if admitted	80% after plan deductible (except if not a true emergency, then 60% after plan deductible) *waived if admitted
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities	80% after plan deductible	60% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Contract Year Maximum: 60 days combined	**Note:** If plan includes an inpatient hospital facility copay, the inpatient hospital facility copay does not apply.	**Note:** If plan includes an inpatient hospital facility deductible, the inpatient hospital facility deductible does not apply.
Laboratory and Radiology Services (includes pre-admission testing) **Advanced Radiological Imaging (i.e. MRIs, CAT Scans and PET Scans)** **Note:** The copay applies on a per procedure basis, for any place of service (including inpatient facility, etc.) **Other Laboratory and Radiology Services:**	80% after plan deductible	60% after plan deductible
Physician's Office Visit	80% after plan deductible	60% after plan deductible
Outpatient Hospital Facility	80% after plan deductible	60% after plan deductible
Independent X-ray and/or Lab facility	80% after plan deductible	60% after plan deductible
Outpatient Short-Term Rehabilitative Therapy and Chiropractic Services Contract Year Maximum: 60 days for all therapies combined Includes: Cardiac rehab Physical Therapy Speech Therapy Occupational Therapy Chiropractic Therapy (includes Chiropractors) Pulmonary Rehab Cognitive Therapy	80% after plan deductible **Note:** Outpatient Short Term Rehab copay applies, regardless of place of service, including the home.	60% after plan deductible
Home Health Care Contract Year Maximum: Unlimited *(includes outpatient private nursing when approved as medically necessary)*	80% after plan deductible	60% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Hospice		
Inpatient Services	80% after plan deductible **Note:** If plan includes an Inpatient Hospital Facility copay, the Inpatient Hospital Facility copay does not apply.	60% after plan deductible **Note:** If plan includes an Inpatient Hospital Facility deductible, the Inpatient Hospital Facility deductible does not apply.
Outpatient Services (same coinsurance level as Home Health Care)	80% after plan deductible	60% after plan deductible
Bereavement Counseling		
Services provided as part of Hospice Care		
Inpatient	80% after plan deductible	60% after plan deductible
Outpatient	80% after plan deductible	60% after plan deductible
Services provided by Mental Health Professional	Covered under Mental Health benefit	Covered under Mental Health benefit

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Maternity Care Services		
Initial Visit to Confirm Pregnancy **Note:** OB/GYN provider is considered a Specialist.	80% after plan deductible	60% after plan deductible
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	80% after plan deductible	60% after plan deductible
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist **Note:** OB/GYN provider is considered a Specialist.	80% after plan deductible	60% after plan deductible
Delivery - Facility (Inpatient Hospital, Birthing Center)	80% after plan deductible	60% after plan deductible
Abortion Includes elective and non-elective procedures		
Physician's Office Visit	80% after plan deductible	60% after plan deductible
Inpatient Facility	80% after plan deductible	60% after plan deductible
Outpatient Facility	80% after plan deductible	60% after plan deductible
Physician's Services	80% after plan deductible	60% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Family Planning Services		
Office Visits, Lab and Radiology Tests and Counseling	80% after plan deductible	In-Network coverage only
Note: The standard benefit will include coverage for contraceptive devices (e.g. Depo-Provera, Norplant and Intrauterine Devices (IUDs). Diaphragms will also be covered when services are provided in the physician's office.	Note: Charges billed by an independent x-ray/lab facility or outpatient hospital will be covered under the plan's x-ray/lab benefit.	
Surgical Sterilization Procedures for Vasectomy/Tubal Ligation (excludes reversals)		
Inpatient Facility	80% after plan deductible	60% after plan deductible
Outpatient Facility	80% after plan deductible	60% after plan deductible
Physician's Services	80% after plan deductible	60% after plan deductible
Physician's Office	80% after plan deductible	60% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment Services Not Covered include: • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial means of becoming pregnant are (e.g. Artificial Insemination, In-vitro, GIFT, ZIFT, etc). **Note:** Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.	Not Covered	Not Covered
Organ Transplants *Includes all medically appropriate, non-experimental transplants*		
Office Visit	80% after plan deductible	In-Network coverage only
Inpatient Facility	100% at Lifesource, otherwise 80% after plan deductible	In-Network coverage only
Physician's Services	100% at Lifesource center, otherwise 80% after plan deductible	In-Network coverage only
Lifetime Travel Maximum: $10,000 per transplant	No charge (only available when using Lifesource facility)	In-Network coverage only
Durable Medical Equipment Contract Year Maximum: Unlimited	80% after plan deductible	60% after plan deductible
External Prosthetic Appliances Contract Year Maximum: Unlimited	$200 deductible per Contract Year, then 80% after plan deductible	$200 deductible per Contract Year, then 60% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Nutritional Evaluation Contract Year Maximum: 3 visits per person, however the three visit limit will not apply to the treatment of diabetes	If performed by the PCP or Specialist, then 80% after plan deductible	
Dental Care Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.		
Physician's Office Visit	80% after plan deductible	60% after plan deductible
Inpatient Facility	80% after plan deductible	60% after plan deductible
Outpatient Facility	80% after plan deductible	60% after plan deductible
Physician's Services	80% after plan deductible	60% after plan deductible
Routine Foot Disorders	Not covered except for services associated with foot care for diabetes and peripheral vascular disease.	Not covered except for services associated with foot care for diabetes and peripheral vascular disease.
Hearing Services	80% after plan deductible	In-Network coverage only
Hearing Aids **(Must be obtained at a CMG facility)** Maximum: $1,100 per ear once every 3 years.	No charge after plan deductible	In-Network coverage only
Varicose Vein Treatment		
Physician's Office Visit	80% after plan deductible	60% after plan deductible
Inpatient Facility	80% after plan deductible	60% after plan deductible
Outpatient Facility	80% after plan deductible	60% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Physician's Services	80% after plan deductible	60% after plan deductible
Outpatient Alternative Medical Services Calendar Year Maximum 10 visits	$5 per visit, then 100%	In-Network coverage only
Herbal or Homeopathic Products Calendar Year Maximum: $60	No charge	In-Network coverage only
Mental Health/Substance Abuse		
Inpatient Contract Year Maximum: 60 days Mental Health: Acute: based on ratio of 1:1 Partial: based on a ratio of 2:1 Residential: based on a ratio of 2:1 Substance Abuse: Acute detox: requires 24 hour nursing; based on a ratio of 1:1 Acute Inpatient Rehab: requires 24 hour nursing; based on a ratio of 1:1 Partial: based on a ratio of 2:1 Residential: based on a ratio of 2:1	80% after plan deductible	60% after plan deductible
Outpatient Contract Year Maximum: 20 visits	80% after plan deductible	60% after plan deductible
Outpatient Mental Health Group Therapy (One group therapy session equals one individual therapy session)	80% after plan deductible	60% after plan deductible
Intensive Outpatient Contract Year Maximum: Up to 3 programs Based on a ratio of 1:1	50%	50%

Preferred Provider Medical Benefits

Certification Requirements - Out-of-Network

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the Medical Necessity and length of a Hospital Confinement when you or your Dependent require treatment in a Hospital:

- as a registered bed patient;
- for a Partial Hospitalization for the treatment of Mental Health or Substance Abuse;
- for Mental Health or Substance Abuse Residential Treatment Services.

You or your Dependent should request PAC prior to any non-emergency treatment in a Hospital described above. In the case of an emergency admission, you should contact the Review Organization within 48 hours after the admission. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued Hospital Confinement.

Covered Expenses incurred will be reduced by 50% for Hospital charges made for each separate admission to the Hospital:

- unless PAC is received: (a) prior to the date of admission; or (b) in the case of an emergency admission, within 48 hours after the date of admission.

Covered Expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below will not include:

- Hospital charges for Bed and Board, for treatment listed above for which PAC was performed, which are made for any day in excess of the number of days certified through PAC or CSR; and
- any Hospital charges for treatment listed above for which PAC was requested, but which was not certified as Medically Necessary.

GM6000 PAC1V33C

PAC and CSR are performed through a utilization review program by a Review Organization with which CG has contracted.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

GM6000 PAC2V9C

Outpatient Certification Requirements - Out-of-Network

Outpatient Certification refers to the process used to certify the Medical Necessity of outpatient diagnostic testing and outpatient procedures, including, but not limited to, those listed in this section when performed as an outpatient in a Free-standing Surgical Facility, Other Health Care Facility or a Physician's office. You or your Dependent should call the toll-free number on the back of your I.D. card to determine if Outpatient Certification is required prior to any outpatient diagnostic testing or procedures. Outpatient Certification is performed through a utilization review program by a Review Organization with which CG has contracted. Outpatient Certification should only be requested for nonemergency procedures or services, and should be requested by you or your Dependent at least four working days (Monday through Friday) prior to having the procedure performed or the service rendered.

Covered Expenses incurred will be reduced by 50% for charges made for any outpatient diagnostic testing or procedure performed unless Outpatient Certification is received prior to the date the testing or procedure is performed.

Covered Expenses incurred will not include expenses incurred for charges made for outpatient diagnostic testing or procedures for which Outpatient Certification was performed, but, which was not certified as Medically Necessary.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

Diagnostic Testing and Outpatient Procedures

Including, but not limited to:

Advanced radiological imaging – CT Scans, MRI, MRA or PET scans.

Hysterectomy

GM6000 SC1 PAC4OCR8V5

Prior Authorization/Pre-Authorized

The term Prior Authorization means the approval that a Participating Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this policy.

Services that require Prior Authorization include, but are not limited to:

- inpatient Hospital services;
- inpatient services at any participating Other Health Care Facility;
- residential treatment;
- outpatient facility services;
- advanced radiological imaging;
- nonemergency ambulance; or
- transplant services.

GM6000 05BPT16 V6

Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below if they are incurred after he becomes insured for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician, and are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by CG. **Any applicable Copayments, Deductibles or limits are shown in The Schedule.**

Covered Expenses

- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in The Schedule.
- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
- charges made for Emergency Services and Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.

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- charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration.

GM6000 CM6
FLX108V748

- charges made for an annual Papanicolaou laboratory screening test.
- charges made for an annual prostate-specific antigen test (PSA).
- charges for appropriate counseling, medical services connected with surgical therapies, including vasectomy and tubal ligation.
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives.
- charges made for Routine Preventive Care from age 3 including immunizations, not to exceed the maximum shown in the Schedule. Routine Preventive Care means health care assessments, wellness visits and any related services.
- charges made for visits for routine preventive care of a Dependent child during the first two years of that Dependent child’s life, including immunizations.
- charges made for hearing services.
- charges made for hearing aids, including, but not limited to semi-implantable hearing devices, audient bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound. Must be obtained at a CMG facility.
- charges made for the following outpatient alternative medical services: physician assessment, acupuncture,

acupressure, physical medicine, guided imagery, massage therapy, biofeedback, and such other services as may be specifically approved by the Healthplan Medical Director.

- charges made for herbal or homeopathic products which are approved by the Healthplan, not to exceed to the maximum shown in The Schedule. Must be obtained at the Designated Alternative Medicine Center.

GM6000 CM6
FLX108V753

Clinical Trials

- charges made for routine patient services associated with cancer clinical trials approved and sponsored by the federal government. In addition the following criteria must be met:
- the trial investigates a treatment for terminal cancer and: (1) the person has failed standard therapies for the disease; (2) cannot tolerate standard therapies for the disease; or (3) no effective nonexperimental treatment for the disease exists;
- the person meets all inclusion criteria for the clinical trial and is not treated "off-protocol";
- the trial is approved by the Institutional Review Board of the institution administering the treatment; and
- the clinical trial must be approved by at least one of the following:
  - one of the National Institutes of Health;
  - an NIH cooperative group or center;
  - the US FDA in the form of an investigational new drug application;
  - the US Department of Defense;
  - the US Department of Veterans' Affairs;
  - a qualified research entity that meets the qualifications of the NIH for grant eligibility;
  - a panel of recognized experts within academic health institutions in AZ.
- coverage will not be extended to clinical trials conducted at nonparticipating facilities if a person is eligible to participate in a covered clinical trial from a Participating Provider.

Routine patient services do not include, and reimbursement will not be provided for:

- any drug or device in a Phase I cancer trial;
- the investigational service or supply itself;
- treatment and services provided outside of Arizona;
- services or supplies listed herein as Exclusions;
- services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs);
- services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant;
- nonhealth services that might be required to receive treatment or intervention.

Genetic Testing

- charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:
  - a person has symptoms or signs of a genetically-linked inheritable disease;
  - it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or

GM6000 05BPT1 V3 (2)

  - the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per contract year for both pre- and postgenetic testing.

Nutritional Evaluation

- charges made for nutritional evaluation and counseling when diet is a part of the medical management of a documented organic disease.

Internal Prosthetic/Medical Appliances

- charges made for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

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- charges made in connection with mammograms for breast cancer screening performed on dedicated equipment for diagnostic purposes on referral by a patient's Physician, not fewer than; (a) a baseline mammogram for women ages 35 to 39, inclusive; (b) a mammogram for women ages 40 to 49, inclusive, every two years or more frequently based on

the attending Physician's recommendation; or (c) a mammogram every year for women age 50 and over;

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- charges incurred at birth for the delivery of a child only to the extent that they exceed the birth mother's coverage, if any, provided: (a) that child is legally adopted by you within one year from date of birth; (b) you are legally obligated to pay the cost of the birth; (c) you notify CG of the adoption within 60 days after approval of the adoption or a change in the insurance policies, plans or company; and (d) you choose to file a claim for such expenses subject to all other terms of these Medical Benefits.

GM6000 CM6
INDEM93

- charges made for medical foods to treat inherited metabolic disorders. Metabolic disorders triggering medical food coverage are: (a) part of the newborn screening program as prescribed by Arizona statute; (b) involve amino acid, carbohydrate or fat metabolism; (c) have medically standard methods of diagnosis, treatment and monitoring, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues; and (d) require specifically processed or treated medical foods that are generally available only under the supervision and direction of a Physician, that must be consumed throughout life and without which the person may suffer serious mental or physical impairment.

For the purpose of this section, the following definitions apply:

- "Inherited Metabolic Disorder" means a disease caused by an inherited abnormality of body chemistry and includes a disease tested under the new born screening program as prescribed by Arizona statute.
- "Medical Foods" means modified low protein foods and metabolic formula.
- "Metabolic Formula" means foods that are all of the following: (a) formulated to be consumed or administered internally under the supervision of a medical doctor or doctor of osteopathy; (b) processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs; (c) administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrients requirements as established by medical evaluation; and (d) essential to a person's optimal growth, health and metabolic homeostasis.
- "Modified Low Protein Foods" means foods that are all of the following: (a) formulated to be consumed or administered internally under the supervision of a medical doctor or doctor of osteopathy; (b) processed or formulated to contain less than one gram of protein per unit of serving, but does not include a natural food that is naturally low in protein; (c) administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrients requirements as established by medical evaluation; and (d) essential to a person's optimal growth, health and metabolic homeostasis.

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The following benefits will apply to insulin and noninsulin-dependent diabetics as well as covered individuals who have elevated blood sugar levels due to pregnancy or other medical conditions:

- charges for Durable Medical Equipment, including glucagon emergency kits and podiatric appliances, related to diabetes. A special maximum will not apply.
- charges for training by a Physician, including a podiatrist with recent education in diabetes management, but limited to the following:
  - Medically Necessary visits when diabetes is diagnosed;
  - visits following a diagnosis of a significant change in the symptoms or conditions that warrant change in self-management;
  - visits when reeducation or refresher training is prescribed by the Physician; and
  - Medical Nutrition therapy related to diabetes management.

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Home Health Services

- charges made for Home Health Services when you: (a) require skilled care; (b) are unable to obtain the required care as an ambulatory outpatient; and (c) do not require confinement in a Hospital or Other Health Care Facility.

  Home Health Services are provided only if CG has determined that the home is a medically appropriate setting. If you are a minor or an adult who is dependent upon others for nonskilled care and/or custodial services (e.g., bathing, eating, toileting), Home Health Services will be provided for you only during times when there is a family member or care giver present in the home to meet your nonskilled care and/or custodial services needs.

  Home Health Services are those skilled health care services

and medical social services that can be provided during visits by Other Health Care Professionals. Home Health Services must be: prescribed by a Physician in lieu of Hospital services; performed by a licensed home health care agency; and must qualify as Covered Expenses if performed in a Hospital; and must be reviewed by a Physician at least every 30 days. Certain services performed by residents and interns may be covered. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Health Care Professionals. A visit is defined as a period of 2 hours or less. Home Health Services are subject to a maximum of 16 hours in total per day. Necessary consumable medical supplies and home infusion therapy administered or used by Other Health Care Professionals in providing Home Health Services are covered. Home Health Services do not include services by a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house even if that person is an Other Health Care Professional. Skilled nursing services or private duty nursing services provided in the home are subject to the Home Health Services benefit terms, conditions and benefit limitations. Physical, occupational, and other Short-Term Rehabilitative Therapy services provided in the home are not subject to the Home Health Services benefit limitations in the Schedule, but are subject to the benefit limitations described under Short-term Rehabilitative Therapy Maximum shown in The Schedule.

GM6000 05BPT104 V2

Hospice Care Services

- charges made for a person who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:
  - by a Hospice Facility for Bed and Board and Services and Supplies, except that, for any day of confinement in a private room, Covered Expenses will not include that portion of charges which is more than the Hospice Bed and Board Daily Limit shown in The Schedule;
  - by a Hospice Facility for services provided on an outpatient basis;
  - by a Physician for professional services;
  - by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
  - for pain relief treatment, including drugs, medicines and medical supplies;
  - by an Other Health Care Facility for:
    - part-time or intermittent nursing care by or under the supervision of a Nurse;
    - part-time or intermittent services of an Other Health Care Professional;

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  - physical, occupational and speech therapy;
  - medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

The following charges for Hospice Care Services are not included as Covered Expenses:

- for the services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
- for any period when you or your Dependent is not under the care of a Physician;
- for services or supplies not listed in the Hospice Care Program;
- for any curative or life-prolonging procedures;
- to the extent that any other benefits are payable for those expenses under the policy;
- for services or supplies that are primarily to aid you or your Dependent in daily living;

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Mental Health and Substance Abuse Services

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.

Substance Abuse is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of Substance Abuse.

Inpatient Mental Health Services

Services that are provided by a Hospital while you or your Dependent is Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services

include Partial Hospitalization and Mental Health Residential Treatment Services.

Inpatient Mental Health services are exchangeable with **Partial Hospitalization** sessions when services are provided for not less than 4 hours and not more than 12 hours in any 24-hour period. The exchange for services will be two Partial Hospitalization sessions are equal to one day of inpatient care.

Mental Health Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Mental Health conditions.

Mental Health Residential Treatment services are exchanged with Inpatient Mental Health services at a rate of two days of Mental Health Residential Treatment being equal to one day of Inpatient Mental Health Treatment.

GM6000 INDEM9V51

Mental Health Residential Treatment Center means an institution which (a) specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; (b) provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; (c) provides 24-hour care, in which a person lives in an open setting; and (d) is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Mental Health Residential Treatment Center when she/he is a registered bed patient in a Mental Health Residential Treatment Center upon the recommendation of a Physician.

Outpatient Mental Health Services

Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent is not Confined in a Hospital, and is provided in an individual, group or Mental Health Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week. Mental Health Intensive Outpatient Therapy Program services are exchanged with Outpatient Mental Health services at a rate of one visit of Mental Health Intensive Outpatient Therapy being equal to one visit of Outpatient Mental Health Services.

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Inpatient Substance Abuse Rehabilitation Services

Services provided for rehabilitation, while you or your Dependent is Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Abuse Services include Partial Hospitalization sessions and Residential Treatment services.

Inpatient Substance Abuse services are exchangeable with **Partial Hospitalization** sessions when services are provided for not less than 4 hours and not more than 12 hours in any 24-hour period. The exchange for services will be two Partial Hospitalization sessions are equal to one day of inpatient care.

Substance Abuse Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Substance Abuse conditions.

Substance Abuse Residential Treatment services are exchanged with Inpatient Substance Abuse services at a rate of two days of Substance Abuse Residential Treatment being equal to one day of Inpatient Substance Abuse Treatment.

Substance Abuse Residential Treatment Center means an institution which (a) specializes in the treatment of psychological and social disturbances that are the result of Substance Abuse; (b) provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; (c) provides 24-hour care, in which a person lives in an open setting; and (d) is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Substance Abuse Residential Treatment Center when she/he is a registered bed patient in a Substance Abuse Residential Treatment Center upon the recommendation of a Physician.

Outpatient Substance Abuse Rehabilitation Services

Services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual or Substance Abuse Intensive Outpatient Therapy Program.

A Substance Abuse Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Abuse program. Intensive Outpatient Therapy Programs provide a combination

of individual, family and/or group therapy in a day, totaling nine, or more hours in a week. Substance Abuse Intensive Outpatient Therapy Program services are exchanged with Outpatient Substance Abuse services at a rate of one visit of Substance Abuse Intensive Outpatient Therapy being equal to one visit of Outpatient Substance Abuse Rehabilitation Services.

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Substance Abuse Detoxification Services

Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. CG will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Exclusions

The following are specifically excluded from Mental Health and Substance Abuse Services:

- Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement.
- Treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- Counseling for activities of an educational nature.
- Counseling for borderline intellectual functioning.
- Counseling for occupational problems.
- Counseling related to consciousness raising.
- Vocational or religious counseling.
- I.Q. testing.
- Custodial care, including but not limited to geriatric day care.
- Psychological testing on children requested by or for a school system.
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

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Durable Medical Equipment

- charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by CG for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the person's responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the utilization review Physician.

Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of Injury or Sickness; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, respirators, wheel chairs, and dialysis machines.

Durable Medical Equipment items that are not covered include but are not limited to those that are listed below:

- **Bed Related Items:** bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including nonpower mattresses, custom mattresses and posturepedic mattresses.
- **Bath Related Items:** bath lifts, nonportable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.
- **Chairs, Lifts and Standing Devices:** computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer), and auto tilt chairs.
- **Fixtures to Real Property:** ceiling lifts and wheelchair ramps.
- **Car/Van Modifications.**
- **Air Quality Items:** room humidifiers, vaporizers, air purifiers and electrostatic machines.
- **Blood/Injection Related Items:** blood pressure cuffs, centrifuges, nova pens and needleless injectors.
- **Other Equipment:** heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.

GM6000 05BPT3

External Prosthetic Appliances and Devices

- charges made or ordered by a Physician for the initial purchase and fitting of external prosthetic appliances and

devices available only by prescription and necessary for the alleviation or correction of Injury, Sickness or congenital defect.

External prosthetic appliances and devices shall include prostheses/prosthetic appliances and devices, orthoses and orthotic devices; braces; and splints.

Prostheses/Prosthetic Appliances and Devices

Prostheses/prosthetic appliances and devices are defined as fabricated replacements for missing body parts. Prostheses/prosthetic appliances and devices include, but are not limited to:

- basic limb prostheses;
- terminal devices such as hands or hooks; and
- speech prostheses.

Orthoses and Orthotic Devices

Orthoses and orthotic devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities. Coverage is provided for custom foot orthoses and other orthoses as follows:

- Nonfoot orthoses – only the following nonfoot orthoses are covered:
  - rigid and semirigid custom fabricated orthoses,
  - semirigid prefabricated and flexible orthoses; and
  - rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
- Custom foot orthoses – custom foot orthoses are only covered as follows:
  - for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
  - when the foot orthosis is an integral part of a leg brace and it is necessary for the proper functioning of the brace;
  - when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputation) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
  - for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

GM6000 05BPT4

The following are specifically excluded orthoses and orthotic devices:

- prefabricated foot orthoses;
- cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;
- orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- orthoses primarily used for cosmetic rather than functional reasons; and
- orthoses primarily for improved athletic performance or sports participation.

Braces

A Brace is defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part.

The following braces are specifically excluded: Copes scoliosis braces.

Splints

A Splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts.

Coverage for replacement of external prosthetic appliances and devices is limited to the following:

- Replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
- Replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
- Coverage for replacement is limited as follows:
  - No more than once every 24 months for persons 19 years of age and older and
  - No more than once every 12 months for persons 18 years of age and under.
  - Replacement due to a surgical alteration or revision of the site.

The following are specifically excluded external prosthetic appliances and devices:

- External and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
- Myoelectric prostheses peripheral nerve stimulators.

GM6000 05BPT5 (2)

Short-Term Rehabilitative Therapy and Chiropractic Care Services

- charges made for Short-term Rehabilitative Therapy that is part of a rehabilitative program, including physical, speech, occupational, cognitive, osteopathic manipulative, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting. Also included are services that are provided by a chiropractic Physician when provided in an outpatient setting. Services of a chiropractic Physician include the conservative

management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment that is rendered to restore motion, reduce pain and improve function.

The following limitations apply to Short-term Rehabilitative Therapy and Chiropractic Care Services:

- To be covered all therapy services must be restorative in nature. Restorative Therapy services are services that are designed to restore levels of function that had previously existed but that have been lost as a result of Injury or Sickness. Restorative Therapy services do not include therapy designed to acquire levels of function that had not been previously achieved prior to the Injury or Sickness.
- Services are not covered if they are custodial, training, educational or developmental in nature.
- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness.

Short-term Rehabilitative Therapy and Chiropractic Care Services that are not covered include but are not limited to:

- Sensory integration therapy, group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder;
- Treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or Injury;
- Maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrences or to maintain the patient's current status;

The following are specifically excluded from Chiropractic Care Services:

- Services of a chiropractor which are not within his scope of practice, as defined by state law;
- Charges for care not provided in an office setting;
- Vitamin therapy.

If multiple outpatient services are provided on the same day they constitute one visit.

GM6000 05BPT8 (2)

Transplant Services

- charges made for human organ and tissue transplant services which include solid organ and bone marrow/stem cell procedures at designated facilities throughout the United States or its territories. This coverage is subject to the following conditions and limitations.

  Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel, liver or multiple viscera.

  All Transplant services, other than cornea, are payable at 100% when received at CIGNA LIFESOURCE Transplant Network® Facilities. Cornea transplants are not covered at CIGNA LIFESOURCE Transplant Network® facilities. Transplant services, including cornea, when received from Participating Provider facilities other than CIGNA LIFESOURCE Transplant Network® facilities are payable at the In-Network level. Transplant services received at any other facilities are not covered.

  Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Transplant Travel Services

Charges made for reasonable travel expenses incurred by you in connection with a preapproved organ/tissue transplant are covered subject to the following conditions and limitations. Transplant travel benefits are not available for cornea transplants. Benefits for transportation, lodging and food are available to you only if you are the recipient of a preapproved organ/tissue transplant from a designated CIGNA LIFESOURCE Transplant Network® facility. The term recipient is defined to include a person receiving authorized transplant related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) post-transplant care. Travel expenses for the person receiving the transplant will include charges for: transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility); lodging while at, or traveling to and from the transplant site; and food while at, or traveling to and from the transplant site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver. The following are specifically excluded travel expenses:

travel costs incurred due to travel within 60 miles of your home; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

These benefits are only available when the covered person is the recipient of an organ transplant. No benefits are available when the covered person is a donor.

GM6000 05BPT7 V7 (2)

Breast Reconstruction and Breast Prostheses

- charges made for reconstructive surgery following a mastectomy; benefits include: (a) surgical services for reconstruction of the breast on which surgery was performed; (b) surgical services for reconstruction of the nondiseased breast to produce symmetrical appearance; (c) postoperative breast prostheses; and (d) mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

Reconstructive Surgery

- charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that: (a) the surgery or therapy restores or improves function; (b) reconstruction is required as a result of Medically Necessary, noncosmetic surgery; or (c) the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

GM6000 05BPT2 V2

Medical Conversion Privilege

For You and Your Dependents

When a person's Medical Expense Insurance ceases, he may be eligible to be insured under an individual policy of medical care benefits (called the Converted Policy). A Converted Policy will be issued by CG only to a person who is Entitled to Convert, and only if he applies in writing and pays the first premium for the Converted Policy to CG within 31 days after the date his insurance ceases. Evidence of good health is not needed.

Employees Entitled to Convert

You are Entitled to Convert Medical Expense Insurance for yourself and all of your Dependents who are insured when your insurance ceased, except a Dependent who is eligible for Medicare or would be Overinsured, but only if:

- Your insurance ceased because:
  - you were no longer in Active Service or
  - you were no longer eligible for Medical Expense Insurance.
- You are not eligible for Medicare.
- You would not be Overinsured.

If you retire you may apply for a Converted Policy within 31 days after your retirement date in place of any continuation of your insurance that may be available under this plan when you retire, if you are otherwise Entitled to Convert.

Dependents Entitled to Convert

The following Dependents are also Entitled to Convert:

- a child whose insurance under this plan ceases because he no longer qualifies as a Dependent or because of your death;
- a spouse whose insurance under this plan ceases due to divorce, annulment of marriage or your death;
- your Dependents, if you are not Entitled to Convert solely because you are eligible for Medicare;

but only if that Dependent: (a) was insured when your insurance ceased; (b) is not eligible for Medicare; and (c) would not be Overinsured.

GM6000 CP1V-8
GM6000 CP2
CON5

Overinsured

A person will be considered Overinsured if either of the following occurs:

- His insurance under this plan is replaced by similar group coverage within 31 days.
- The benefits under the Converted Policy, combined with Similar Benefits, result in an excess of insurance based on CG's underwriting standards for individual policies. Similar Benefits are: (a) those for which the person is covered by another hospital, surgical or medical expense insurance policy, or a hospital, or medical service subscriber contract, or a medical practice or other prepayment plan or by any other plan or program; (b) those for which the person is eligible, whether or not covered, under any plan of group coverage on an insured or uninsured basis; or (c) those available for the person by or through any state, provincial or federal law.

Converted Policy

The Converted Policy will be one of CG's current offerings at the time the first premium is received based on its rules for Converted Policies. It will comply with the laws of the jurisdiction where the group medical policy is issued. However, if the applicant for the Converted Policy resides elsewhere, the Converted Policy will be on a form which meets the conversion requirements of the jurisdiction where he resides. The Converted Policy offering may include medical benefits on a group basis. The Converted Policy need not provide major medical coverage unless it is required by the laws of the jurisdiction in which the Converted Policy is issued.

GM6000 CON26

The Converted Policy will be issued to you if you are Entitled to Convert, insuring you and those Dependents for whom you may convert. If you are not Entitled to Convert and your spouse and children are, it will be issued to the spouse, covering all such Dependents. Otherwise, a Converted Policy will be issued to each Dependent who is Entitled to Convert. The Converted Policy will take effect on the day after the person's insurance under this plan ceases. The premium on its effective date will be based on: (a) class of risk and age; and (b) benefits.

The Converted Policy may not exclude any pre-existing condition not excluded by this plan. During the first 12 months the Converted Policy is in effect, the amount payable under it will be reduced so that the total amount payable under the Converted Policy and the Medical Benefits Extension of this plan will not be more than the amount that would have been payable under this plan if the person's insurance had not ceased. After that, the amount payable under the Converted Policy will be reduced by any amount still payable under the Medical Benefits Extension of this plan.

CG or the Policyholder will give you, on request, further details of the Converted Policy.

GM6000 CON29

Prescription Drug Benefits

The Schedule

For You and Your Dependents

This plan provides Prescription Drug benefits for Prescription Drugs and Related Supplies provided by Pharmacies as shown in this Schedule. To receive Prescription Drug Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for Prescription Drugs and Related Supplies for each 30-day supply at a retail pharmacy or each 90-day supply at a mail order pharmacy. That portion is the Copayment, Deductible or Coinsurance.

Coinsurance

The term Coinsurance means the percentage of charges for covered Prescription Drugs and Related Supplies that you or your Dependent are required to pay under this plan.

Copayments/Deductibles

Copayments are expenses to be paid by you or your Dependent for covered Prescription Drugs and Related Supplies. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from and not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance.

Contract Year Deductible

Deductibles are expenses to be paid by you or your Dependent for Covered Prescription Drugs. These Deductibles are in addition to any copayments or coinsurance. Once the Deductible maximum shown in The Schedule has been reached you and your family need not satisfy any further Prescription Drug Deductible for the rest of that year.

Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred at a Pharmacy for Prescription Drugs and Related Supplies for which no payment is provided because of the Coinsurance factor and any Copayments or Deductibles. Once the Out-of-Pocket maximum shown in The Schedule has been reached you and your family need not satisfy any further Out-of-Pocket maximum for the rest of that year.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Contract Year Deductible		
Individual	$1,100 Combined Medical/Pharmacy	In Network Only
Family	$2,200 Combined Medical/Pharmacy	In Network Only

Out-of-Pocket Maximum		
Individual	$5,000 Combined Medical/Pharmacy	In Network Only
Family	$10,000 Combined Medical/Pharmacy	In Network Only

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
Prescription Drugs Generic*drugs on the Prescription Drug List	30% per prescription order or refill after plan deductible	In-network coverage only
Brand-Name * drugs designated as preferred on the Prescription Drug List with no Generic equivalent	40% per prescription order or refill after plan deductible	In-network coverage only
Brand-Name * drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	50% per prescription order or refill after plan deductible	In-network coverage only
* Designated as per generally-accepted industry sources and adopted by CG		
Mail-Order Drugs Generic * drugs on the Prescription Drug List	30% per prescription order or refill after plan deductible	In-network coverage only
Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent	40% per prescription order or refill after plan deductible	In-network coverage only
Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	50% per prescription order or refill after plan deductible	In-network coverage only
* Designated as per generally-accepted industry sources and adopted by CG		

Prescription Drug Benefits
For You and Your Dependents

Covered Expenses

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, CG will provide coverage for those expenses as shown in the Schedule. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When you or a Dependent is issued a prescription for Medically Necessary Prescription Drugs or Related Supplies as part of the rendering of Emergency Services and that prescription cannot reasonably be filled by a Participating Pharmacy, the prescription will be covered by CG, as if filled by a Participating Pharmacy.

Limitations

Each Prescription Order or refill shall be limited as follows:

- up to a consecutive 30-day supply, at a retail Pharmacy, unless limited by the drug manufacturer's packaging: or
- up to a consecutive 90-day supply at a mail-order Participating Pharmacy, unless limited by the drug manufacturer's packaging; or
- to a dosage and/or dispensing limit as determined by the P&T Committee.

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Coverage for certain Prescription Drugs and Related Supplies requires your Physician to obtain authorization prior to prescribing. If your Physician wishes to request coverage for Prescription Drugs or Related Supplies for which prior authorization is required, your Physician may call or complete the appropriate prior authorization form and fax it to CG to request prior authorization for coverage of the Prescription Drugs or Related Supplies. Your Physician should make this request before writing the prescription.

If the request is approved, your Physician will receive confirmation. The authorization will be processed in our claim system to allow you to have coverage for those Prescription Drugs or Related Supplies. The length of the authorization will depend on the diagnosis and Prescription Drugs or Related Supplies. When your Physician advises you that coverage for the Prescription Drugs or Related Supplies has been approved, you should contact the Pharmacy to fill the prescription(s).

If the request is denied, your Physician and you will be notified that coverage for the Prescription Drugs or Related Supplies is not authorized.

If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the Policy, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered.

If you have questions about a specific prior authorization request, you should call Member Services at the toll-free number on the ID card.

All drugs newly approved by the Food and Drug Administration (FDA) are designated as either non-Preferred or non-Prescription Drug List drugs until the P & T Committee clinically evaluates the Prescription Drug for a different designation.

Prescription Drugs that represent an advance over available therapy according to the FDA will be reviewed by the P&T Committee within six months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA, will not be reviewed by the P&T Committee for at least six months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug.

Your Payments

Coverage for Prescription Drugs and Related Supplies purchased at a Pharmacy is subject to the Copayment or Coinsurance shown in the Schedule, after you have satisfied your Prescription Drug Deductible, if applicable. Please refer to the Schedule for any required Copayments, Coinsurance, Deductibles or Maximums if applicable.

GM6000 PHARM92 PHARM115(2)
GM6000 PHARM93
GM6000 PHARM87

Exclusions

No payment will be made for the following expenses:

- drugs available over the counter that do not require a prescription by federal or state law;
- any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
- injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. The following are examples of Physician supervised drugs: Injectables used to treat hemophilia and RSV (respiratory syncytial virus),

chemotherapy injectables and endocrine and metabolic agents.

- any drugs that are experimental or investigational as described under the Medical "Exclusions" section of your certificate;
- charges for an off-label cancer drug that has been prescribed for a specific type of cancer for which use of the drug has not been approved by the U.S. Food and Drug Administration (U.S. FDA). However, such drugs will be covered if : (a) the drug is recognized as safe and effective for treatment of the specific type of cancer in one of the standard medical reference compendia or in medical literature; and (b) the drug has not been determined by the FDA to be contraindicated for the specific type of cancer being treated;
- prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies;
- implantable contraceptive products;
- any fertility drug;
- drugs used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmy, and decreased libido;
- prescription vitamins (other than prenatal vitamins), dietary supplements, and fluoride products;
- for nutritional or dietary supplements, except as described in the Medical “Covered Expenses” section.
- drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products;
- diet pills or appetite suppressants (anorectics);
- prescription smoking cessation products;
- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;
- replacement of Prescription Drugs and Related Supplies due to loss or theft;
- drugs used to enhance athletic performance;
- drugs which are to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
- prescriptions more than one year from the original date of issue.

Other limitations are shown in the Medical "Exclusions" section.

GM6000 PHARM88 PHARM127 V1 (3)
GM6000 PHARM89

GM6000 PHARM105

Reimbursement/Filing a Claim

When you or your Dependents purchase your Prescription Drugs or Related Supplies through a retail Participating Pharmacy, you pay any applicable Copayment, Coinsurance or Deductible shown in the Schedule at the time of purchase. You do not need to file a claim form.

To purchase Prescription Drugs or Related Supplies from a mail-order Participating Pharmacy, see your mail-order drug introductory kit for details, or contact member services for assistance.

See your Employer's Benefit Plan Administrator to obtain the appropriate claim form.

GM6000 PHARM94 V17

Exclusions, Expenses Not Covered and General Limitations

Additional coverage limitations determined by plan or provider type are shown in the Schedule. Payment for the following is specifically excluded from this plan:

- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- to the extent that payment is unlawful where the person resides when the expenses are incurred.
- charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- for or in connection with an Injury or Sickness which is due to war, declared or undeclared.
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- for or in connection with experimental, investigational or unproven services.

  Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:

- not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
- not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
- the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section of this plan; or
- the subject of an ongoing phase I, II or III clinical trial, except as provided in the "Clinical Trials" section of this plan.

- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- regardless of clinical indication for macromastia or gynecomastia surgeries; abdominoplasty/panniculectomy; rhinoplasty; blepharoplasty; orthognathic surgeries; redundant skin surgery; removal of skin tags; craniosacral/cranial therapy; dance therapy, movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- surgical or nonsurgical treatment of TMJ dysfunction.
- for or in connection with treatment of the teeth or periodontium unless such expenses are incurred for: (a) charges made for a continuous course of dental treatment started within six months of an Injury to sound natural teeth; (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; (c) charges made by a Free-Standing Surgical Facility or the outpatient department of a Hospital in connection with surgery.
- for medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- reversal of male and female voluntary sterilization procedures.
- transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.

- aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- medical benefits for eyeglasses, contact lenses or examinations for prescription or fitting thereof, except that Covered Expenses will include the purchase of the first pair of eyeglasses, lenses, frames or contact lenses that follows keratoconus or cataract surgery.
- charges made for or in connection with routine refractions, eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn.
- all noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- cosmetics, dietary supplements and health and beauty aids.
- For nutritional or dietary supplements, unless those charges are for medical foods to treat inherited metabolic disorders. Metabolic disorders triggering medical food coverage are: (a) part of the newborn screening program as prescribed by Arizona statute; (b) involve amino acid, carbohydrate or fat metabolism; (c) have medically standard methods of diagnosis, treatment and monitoring, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues; and (d) require specifically processed or treated medical foods that are generally available only under the supervision and direction of a Physician, that must be consumed throughout life and without which the person may suffer serious mental or physical impairment.
- medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.
- medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- telephone, e-mail, and Internet consultations, and telemedicine.
- for charges which would not have been made if the person had no insurance.
- to the extent that they are more than Maximum Reimbursable Charges.
- expenses incurred outside the United States or Canada, unless you or your Dependent is a U.S. or Canadian resident and the charges are incurred while traveling on business or for pleasure.
- charges made by any covered provider who is a member of your family or your Dependent's family.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.
- charges for an off-label cancer drug that has been prescribed for a specific type of cancer for which use of the drug has been approved by the U.S. Food and Drug Administration (U.S. FDA). However, such drugs will be covered if: (a) the drug is recognized as safe and effective for treatment of the specific type of cancer in one of the standard medical reference compendia or in medical literature;and (b) the drug has not been determined by the FDA to be contradicted for the specific type of cancer being treated. Coverage will also be provided for any medical services necessary to administer the drug.

GM6000 05BPT14 V106 (8)

Pre-existing Condition Limitations

No payment will be made for Covered Expenses for or in connection with an Injury or a Sickness which is a Pre-existing Condition, unless those expenses are incurred after a continuous one-year period during which a person is satisfying a waiting period and/or is insured for these benefits.

Pre-existing Condition

A Pre-existing Condition is an Injury or a Sickness for which a person receives treatment, incurs expenses or receives a diagnosis from a Physician during the 90 days before the earlier of the date a person begins an eligibility waiting period, or becomes insured for these benefits.

Exceptions to Pre-existing Condition Limitation

Pregnancy, and genetic information with no related treatment, will not be considered Pre-existing Conditions.

A newborn child, an adopted child, or a child placed for adoption before age 18 will not be subject to any Pre-existing Condition limitation if such child was covered within 31 days of birth, adoption or placement for adoption. Such waiver will not apply if 63 days elapse between coverage during a prior period of Creditable Coverage and coverage under this plan.

Credit for Coverage Under Prior Plan

If a person was previously covered under a plan which qualifies as Creditable Coverage, the following will apply, provided he notifies the Employer of such prior coverage, and fewer than 63 days elapse between coverage under the prior plan and coverage under this plan, including any waiting period

CG will reduce any Pre-existing Condition limitation period under this policy by the number of days of prior Creditable Coverage you had under a creditable health plan or policy.

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Certification of Prior Creditable Coverage

You must provide proof of your prior Creditable Coverage in order to reduce a Pre-existing Condition limitation period. You should submit proof of prior coverage with your enrollment material. Certification, or other proofs of coverage which need to be submitted outside the standard enrollment form process for any reason, may be sent directly to: Eligibility Services, CIGNA HealthCare, P.O. Box 9077, Melville, NY 11747-9077. You should contact the plan administrator or CIGNA Customer Service Representative if assistance is needed to obtain proof of prior Creditable Coverage. Once your prior coverage records are reviewed and credit is calculated, you will receive a notice of any remaining Pre-existing Condition limitation period.

Creditable Coverage

Creditable Coverage will include coverage under: a self-insured employer group health plan; individual or group health insurance indemnity or HMO plans; state or federal continuation coverage; individual or group health conversion plans; Part A or Part B of Medicare; Medicaid, except coverage solely for pediatric vaccines; the Indian Health Service; the Peace Corps Act; a state health benefits risk pool; a public health plan; health coverage for current and former members of the armed forces and their Dependents; medical savings accounts; and health insurance for federal employees and their Dependents.

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Coordination of Benefits

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

Definitions

For the purposes of this section, the following terms have the meanings set forth below:

Plan

Any of the following that provides benefits or services for medical care or treatment:

- Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies.
- Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Closed Panel Plan

A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

Secondary Plan

A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

GM6000 COB11

Allowable Expense

A necessary, reasonable and customary service or expense,

including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If you are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
- If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.

Claim Determination Period

A calendar year or that part of a calendar year in which the person has been covered under this Plan.

GM6000 COB12V2

Reasonable Cash Value

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;
- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child;
  - then, the Plan of the parent not having custody of the child, and
  - finally, the Plan of the spouse of the parent not having custody of the child.

GM6000 COB13

- The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

Effect on the Benefits of This Plan

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses.

The difference between the amount that this Plan would have paid if this Plan had been the Primary Plan, and the benefit payments that this Plan had actually paid as the Secondary Plan, will be recorded as a benefit reserve for you. CG will use

this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

GM6000 COB14

As each claim is submitted, CG will determine the following:

- CG's obligation to provide services and supplies under this policy;
- whether a benefit reserve has been recorded for you; and
- whether there are any unpaid Allowable Expenses during the Claims Determination Period.

If there is a benefit reserve, CG will use the benefit reserve recorded for you to pay up to 100% of the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero and a new benefit reserve will be calculated for each new Claim Determination Period.

Recovery of Excess Benefits

If CG pays charges for benefits that should have been paid by the Primary Plan, or if CG pays charges in excess of those for which we are obligated to provide under the Policy, CG will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

CG will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

CG, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

GM6000 COB15

Medicare Eligibles

CG will pay as the Secondary Plan as permitted by the Social Security Act of 1965 as amended for the following:

a) a former Employee who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;

b) a former Employee's Dependent, or a former Dependent Spouse, who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;

c) an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Employee is eligible for Medicare due to disability;

d) the Dependent of an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Dependent is eligible for Medicare due to disability;

e) an Employee or a Dependent of an Employee of an Employer who has fewer than 20 Employees, if that person is eligible for Medicare due to age;

f) an Employee, retired Employee, Employee's Dependent or retired Employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months;

GM6000 MEL23 V4

CG will assume the amount payable under:

- Part A of Medicare for a person who is eligible for that Part without premium

payment, but has not applied, to be the amount he would receive if he had applied.

- Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he would receive if he were enrolled.
- Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount he would receive in the absence of such private contract.

A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him.

This reduction will not apply to any Employee and his Dependent or any former Employee and his Dependent unless he is listed under (a) through (f) above.

GM6000 MEL45V2

Payment of Benefits

To Whom Payable

All Medical Benefits are payable to you. However, at the option of CG, all or any part of them may be paid directly to the person or institution on whose charge claim is based.

Medical Benefits are not assignable unless agreed to by CG. CG may, at its option, make payment to you for the cost of any Covered Expenses received by you or your Dependent from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependent is responsible for reimbursing the Provider. If any person to whom benefits are payable is a minor or, in the opinion of CG, is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, CG may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

If you die while any of these benefits remain unpaid, CG may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate.

Payment as described above will release CG from all liability to the extent of any payment made.

Time of Payment

Benefits will be paid by CG when it receives due proof of loss.

Recovery of Overpayment

When an overpayment has been made by CG, CG will have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

Calculation of Covered Expenses

CG, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- the methodologies in the most recent edition of the Current Procedural terminology.
- the methodologies as reported by generally recognized professionals or publications.

GM6000 TRM366

Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- The last day of the pay period in which premium is paid or in which employees cease to be in a benefit eligible position.

Any continuation of insurance must be based on a plan which precludes individual selection.

Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date your Employer: (a) stops paying premium for you; or (b) otherwise cancels your insurance. However, your insurance will not be continued for more than 60 days past the date your Active Service ends.

Injury or Sickness

If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. However, the insurance will not continue past the date your Employer stops paying premium for you or otherwise cancels the insurance.

Retirement
If your Active Service ends because you retire, your insurance will be continued until the date on which your Employer stops paying premium for you or otherwise cancels the insurance.

GM6000 TRM15V44

Dependents

Your insurance for all of your Dependents will cease on the earliest date below:

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

GM6000 TRM62

Reinstatement of Insurance

If your Insurance ceases because you are called to active duty from status as a reservist on or after August 22, 1990, the insurance for you and your Dependents, including those born during your time of active duty, will be reinstated after your deactivation, provided you apply for reinstatement within 90 days of discharge or within one year of continuous hospitalization from the date of discharge.

Such reinstatement will be without the application of: (a) a new waiting period, or (b) a new Pre-existing Condition Limitation. A new Pre-existing Condition Limitation will not be applied to a condition that you or your Dependent may have developed while coverage was interrupted. However, no payment will be made for a condition that was the direct result of active military duty.

GM6000 TER1
TRM186V3

Medical Benefits Extension

Upon Policy Cancellation
If the Medical Benefits under this plan cease for you or your Dependent due to cancellation of the policy, and you or your Dependent is Totally Disabled on that date, due to an Injury or Sickness, Medical Benefits will be paid for Covered Expenses incurred in connection with the Injury or Sickness. However, no benefits will be paid after the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in the Schedule;
- the date you are covered for medical benefits under another group plan;
- the date you or your Dependent is no longer Totally Disabled; or
- 12 months from the date your Medical Benefits cease due to cancellation of the policy; or
- 12 months from the date the policy is canceled.

The terms of this Medical Benefits Extension will not apply to a child born as a result of a pregnancy which exists when you or your Dependent's Medical Benefits cease.

Totally Disabled
You will be considered Totally Disabled if, because of an Injury or Sickness:

- you are unable to perform the basic duties of your occupation;
- you are not performing any other work or engaging in any other occupation for work or profit.

Your Dependent will be considered Totally Disabled if, because of an Injury or Sickness:

- he is unable to engage in the normal activities of a person of the same age, sex and ability; or
- in the case of a Dependent who normally works for wage or profit, he is not performing such work.

GM6000 BEX182 V14

Federal Information

Coverage for Reconstructive Surgery Following Mastectomy

When a person who is insured for benefits under this certificate and who has had a mastectomy at any time, decides to have breast reconstruction, based on consultation between the attending Physician and the patient, the following benefits will be subject to the same coinsurance and deductibles which apply to other plan benefits:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- treatment of physical complications in all stages of mastectomy, including lymphedema; and
- mastectomy bras and external prostheses limited to the lowest cost alternative available that meets the patient's physical needs.

If you have any questions about your benefits under this plan, please call the number on your ID card or contact your Employer.

Coverage for Maternity Hospital Stay

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable.

Please review this Plan for further details on the specific coverage available to you and your Dependents.

NOT101

Notice Regarding Provider/Pharmacy Directories and Provider/Pharmacy Networks

If your Plan utilizes a network of Providers/Pharmacies, you will automatically and without charge, receive a separate listing of Participating Providers/Pharmacies.

You may also have access to a list of Providers who participate in the network by visiting www.cigna.com; mycigna.com or by calling the toll-free telephone number on your ID card.

Your Participating Provider/Pharmacy networks consist of a group of local medical practitioners, and Hospitals, of varied specialties as well as general practice or a group of local Pharmacies who are employed by or contracted with CIGNA HealthCare.

NOT88

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and reemployment in regard to military leaves of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage.

Continuation of Coverage

For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.

For leaves of 31 days or more, you may continue coverage for yourself and your Dependent as follows:

You may continue benefits, by paying the required premium to your Employer, until the earliest of the following:

- 24 months from the last day of employment with the Employer;
- the day after you fail to apply or return to work; and
- the date the policy cancels.

Your Employer may charge you and your Dependents up to 102% of the total premium.

Following continuation of health coverage per USERRA requirements, you may convert to a plan of individual coverage according to any "Conversion Privilege" shown in your certificate.

NOT141

Reinstatement of Benefits (Applicable To All Coverages)

If your coverage ends during the leave because you do not elect USERRA or an available conversion plan at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if, (a) you gave your Employer advance written or verbal notice of your military service leave, and (b) the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of a Pre-existing Condition Limitation (PCL) or waiting period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

Any 63-day break in coverage rule regarding credit for time accrued toward a PCL waiting period will be waived.

NOT142

Notice of An Appeal or a Grievance

The appeal or grievance provision in this certificate may be superseded by the law of your state. Please see your explanation of benefits for the applicable appeal or grievance procedure.

GM6000 NOT90

Notice of Federal Requirements

If your income does not exceed 100% of the official poverty line and your liquid resources are at or below twice the social security income level, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost-effective. This includes premiums for continuation coverage required by federal law.

GM6000 NOT99

Requirements of the Omnibus Budget Reconciliation Act of 1993 (OBRA'93)

These health coverage requirements do not apply to any benefits for loss of life, dismemberment or loss of income.

Any other provisions in this certificate that provide for: (a) the definition of an adopted child and the effective date of eligibility for coverage of that child; and (b) eligibility requirements for a child for whom a court order for medical support is issued; are superseded by these provisions required by the federal Omnibus Budget Reconciliation Act of 1993, as amended, where applicable.

A. Eligibility for Coverage Under a Qualified Medical Child Support Order

If a Qualified Medical Child Support Order is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the Qualified Medical Child Support Order being issued.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

1. the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
2. the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
3. the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
4. the order states the period to which it applies; and
5. if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

OBRA1

The Qualified Medical Child Support Order may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except an order may require a plan to comply with state laws regarding child health care coverage.

Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

B. Eligibility for Coverage for Adopted Children

Any child under the age of 18 who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The provisions in the "Exceptions for Newborns" section of this certificate that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

Any "Pre-existing Condition Limitation" in this certificate will be waived for an adopted child or a child placed for adoption.

OBRA2

Continuation Required By Federal Law

For You and Your Dependents

The Continuation Required by Federal Law does not apply to any benefits for loss of life, dismemberment or loss of income.

Federal law enables you or your Dependent to continue health insurance if coverage would cease due to a reduction of your work hours or your termination of employment (other than for

gross misconduct). Federal law also enables your Dependents to continue health insurance if their coverage ceases due to your death, divorce or legal separation, or with respect to a Dependent child, failure to continue to qualify as a Dependent. Continuation must be elected in accordance with the rules of your Employer's group health plan(s) and is subject to federal law, regulations and interpretations.

A. Employees and Dependents Continuation Provision

If you and your Dependent's insurance would otherwise cease because of a reduction in the number of hours you work or your termination of employment for any reason other than gross misconduct, you or your Dependent may continue health insurance upon payment of the required premium to the Employer. You and your Dependents must elect to continue insurance within 60 days from the later of: (a) the date of a reduction of your work hours or your termination of employment; (b) the date notice of the right to continue insurance is sent; or (c) the date the insurance would otherwise cease. You must pay the first premium within 45 days from the date you elect to continue coverage. Such insurance will not be continued by CG for you and/or your Dependents, as applicable, beyond the earliest of the following dates:

- 18 months from the date your work hours are reduced or your employment terminates, whichever may occur first;
- the date the policy cancels;
- the date coverage ends due to your failure to pay the required subsequent premium within 30 days of the due date;
- the date your Dependent ceases to qualify as an eligible Dependent;
- after you elect to continue this insurance, the date you first become entitled to Medicare, and for your Dependent, the date he first becomes entitled to Medicare;
- after you elect to continue this insurance, for you, the date you first become covered under another group health plan, unless you have a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.

COBRA13

B. Dependent Continuation Provision

If health insurance for your Dependents would otherwise cease because of:

(1) your death;

(2) divorce or legal separation; or

(3) with respect to a Dependent child, failure to continue to qualify as a Dependent,

such insurance may be continued upon payment of the required premium to the Employer. In the case of (2) or (3) above, you or your Dependent must notify your Employer within 60 days of such event. In addition, a Dependent must elect to continue insurance within 60 days from the later of: (a) the date the insurance would otherwise cease; or (b) the date notice of the right to continue insurance is sent.

CG will not continue the health insurance of a Dependent beyond the earliest of the following dates:

- 36 months from the date of (1), (2) or (3) above, whichever may occur first;
- the date coverage ends due to failure to pay the required subsequent premium within 30 days of the due date;
- after the Dependent elects to continue this insurance, the date the Dependent first becomes entitled to Medicare;
- the date the policy cancels; or
- after the Dependent elects to continue this insurance, the date the Dependent first becomes covered under another group health plan, unless the Dependent has a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.

C. Subsequent Events Affecting Dependent Coverage

If, within the initial 18-month continuation period, your Dependent would lose coverage because of an event described in (1), (2), or (3) of Section B, or because of your coverage loss due to your subsequent entitlement to Medicare, after you have continued your Dependent's coverage due to your employment termination or reduction in work hours, your Dependent may continue coverage for up to 36 months from the date of loss of employment or reduction in work hours.

COBRA14

If your employment ends or your work hours are reduced within 18 months after your entitlement to Medicare, your covered Dependent may continue coverage for up to 36 months from the date you become entitled to Medicare.

If your employment ends or your work hours are reduced more than 18 months after your entitlement to Medicare, your covered Dependent may continue coverage for up to 18 months from the date your employment ends or your work hours are reduced.

Disabled Individuals Continuation Provisions

If you or your Dependent is disabled before or within the first 60 days of continuation of coverage which follow termination of employment or a reduction in work hours, the disabled person may continue health insurance for up to an additional 11 months beyond the 18-month period.

If you or your Dependents who are not disabled elect to continue coverage, such family members of the disabled person may extend coverage for up to an additional 11 months, if they otherwise remain eligible, and notice of disability is provided as described in (b), below.

To be eligible you or your Dependent must:

- be declared disabled as of a day before or during the first 60 days of continuation, under Title II or XVI by the Social Security Administration; and
- notify the Plan Administrator of the Social Security Administration's determination within 60 days following the determination and within the initial 18-month continuation period, and provide the Plan Administrator with a copy of the determination.

Termination of coverage for all covered persons during the additional 11 months will occur if the disabled person is found by the Social Security Administration to be no longer disabled. Termination for this reason will occur on the first day of the month beginning more than 30 days after the date of the final determination.

All reasons for termination described in Sections A and B which apply to the initial 18 months will also apply to any or all covered persons for any additional months of coverage.

COBRA4

D. Effect of Employer Chapter 11 Proceedings on Retiree Coverage

If you are covered as a retiree, and a proceeding under USC Chapter 11, bankruptcy for the Employer results in a substantial loss of coverage for you or your Dependents within one year before or after such proceeding, coverage will continue until: (a) for you, your death; and (b) for your Dependent surviving spouse or Dependent child, up to 36 months from your death.

COBRA15

E. Payment of Premium

This Plan may require the payment of an amount that does not exceed 102% of the applicable premium, except this Plan may require payment of up to 150% of the Applicable Premium for any extended period of continuation coverage for a covered person who is disabled. The additional 48% may only be applied to the premium for the rating category that includes the disabled individual, and only for the additional 11 months.

Applicable Premium is determined as follows:

1. if the Employee alone elects to continue coverage, the Employee will be charged the active Employee rate.
2. if a Dependent spouse alone elects to continue coverage, the spouse will be charged the active Employee rate.
3. if a Dependent child or children elect to continue coverage without a parent also electing the continuation, each child will be charged the active Employee rate.
4. if the entire family elects to continue coverage, they will be charged the family rate.
5. if the Schedule of Premium Rates is set up on a step-rate basis, the active rate basis that fits the individuals who elect to continue his coverage is the rate that will be charged. If only children elect to continue coverage, each child will be charged the Employee Only rate.

Timely Payment

If payment is made within the grace period in an amount not significantly less than the amount the Plan requires to be paid, the amount must be deemed to satisfy the Plan's requirement. However, you must be notified and allowed at least 30 days after notice is provided for payment to be made.

F. Providing Notification of Your Status to Health Care Providers During the Grace Period

If, after you elect to continue coverage, a health care provider contacts this Plan to confirm coverage for a period for which premium has not yet been received, the Plan must give a complete and accurate response.

GM6000 COBRA17

G. Notification Requirements

Your Employer should send you initial notification of coverage continuation rights as required by federal law; (a) when the Plan first becomes subject to federal continuation requirements; (b) when you are hired; and (c) when you add a spouse as a Dependent for benefits under the Plan. Receipt of this certificate may serve as such notice.

If you become eligible to continue coverage per federal law, your Employer must send you notification within 14 days. If the Plan has a Plan Administrator, the Employer must notify the Plan Administrator within 30 days. The Plan Administrator must notify you within 14 days, thereafter.

If eligibility to continue coverage is due to divorce, legal separation or a Dependent child losing eligibility for coverage under the Plan, you or your Dependent spouse must notify your Employer within 60 days of such event. Your Employer must notify you of the right to continue coverage within 14 days after receipt of notification of such event.

GM6000 COBRA18

Conversion Available Following Continuation

If you or your Dependent's Continuation ends due to the expiration of the maximum 18-, 29- or 36-month continuation period, whichever applies, you or your Dependent may be entitled to convert to the insurance in accordance with the

Medical Conversion benefit then available to Employees and their Dependents.

Interaction With Other Continuation Benefits

A person who is eligible to continue insurance under both (1) and (2) below may continue the insurance, upon payment of any required premium, for a period of time not to exceed the longer of: (1) the continuation required by federal law; or (2) any other continuation of insurance provided in this Certificate.

Newly Acquired Dependents

If, while your insurance is being continued under the continuation required by federal law provisions, you acquire a new Dependent, such Dependent will be eligible for this Continuation provided:

- the required premium is paid; and
- CG is notified of your newly acquired Dependent in accordance with the terms of the policy.

If events (1) or (2) of Section B should subsequently occur for your newly acquired Dependent spouse, such spouse will not be entitled to continue his insurance. However, your Dependent child will be able to continue his insurance.

If events described in Section C should subsequently occur for your child who is born, adopted or placed for adoption as a newly acquired Dependent, coverage will be continued according to that section.

COBRA5

Requirements of Family and Medical Leave Act of 1993

Any provisions of the policy that provide for: (a) continuation of insurance during a leave of absence; and (b) reinstatement of insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, where applicable:

A. Continuation of Health Insurance During Leave

Your health insurance will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993; and
- you are an eligible Employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

B. Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period or the requirements of any Pre-existing Condition Limitation to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993.

GM6000 TRM191V1

The Following Will Apply To Residents Of Arizona

When You Have A Complaint Or An Appeal

For the purposes of this section, any reference to "you," "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems. The following describes the process by which Members may obtain information and submit concerns regarding service, benefits, and coverage. For more information, see the Benefit Inquiry and Appeals Information Packet ("Appeal Packet"). Upon membership renewal or at any time thereafter, you may request an additional Appeal Packet by contacting Member Services at the toll-free number that appears on your Benefit Identification Card.

Start with Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call our toll-free number and explain your concern to one of our Customer Service representatives. You can also express that concern in writing. Please call or write to us at the following:

Customer Services Toll-Free Number or address that appears on your Benefit Identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

CG has a two step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal

in writing within two years of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call or write to us at the toll-free number or address on your Benefit Identification card, explanation of benefits or claim form.

GM6000 APL590 V1

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

Within five working days after receiving your request for review, CG will mail you and your Primary Care Physician ("PCP") or treating Provider a notice indicating that your request was received, and a copy of the Appeal Packet (sent to PCP or treating Provider upon request). For level one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision). We will respond within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, your PCP or treating Physician certifies in writing and provides supporting documentation that the time frames under this process are likely to cause a significant negative change in your medical condition which cannot be managed without the requested services; or your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. When an appeal is expedited, we will respond orally and in writing with a decision within the lesser of one working day or 72 hours.

GM6000 APL591

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal. Please send your review request relating to denial of a requested service that has not already been provided within 365 days of the last denial. Your review requests relating to payment of a service already provided should be sent within two years of the last denial. To help us make a decision on your appeal, you or your provider should also send us any more information (that you haven't already sent us) to show why we should authorize the requested service or pay the claim.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Physician reviewer in the same or similar specialty as the care under consideration, as determined by CG's Physician reviewer. You may present your situation to the Committee in person or by conference call.

For level two appeals we will acknowledge in writing that we have received your request within five working days after receiving your request and schedule a Committee review. For required preservice and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For postservice claims, the Committee review and written notification of the Appeal Committee's decision will be completed within 30 calendar days. If more time or information is needed to make the preservice or concurrent care determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review.

You may request that the appeal process be expedited if, your Primary Care Physician or treating Physician certifies in writing and provides supporting documentation that the time frames under this process are likely to cause a significant negative change in your medical condition which cannot be managed without the requested services, or your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

At any time during the appeal process CG has the option to send your appeal directly to External Independent Review without making a decision during the appeal process.

GM6000 APL592 V1

External Independent Review

1. Eligibility

   Under Arizona law, a Member may seek an Expedited or Standard External Independent Review only after seeking any available Expedited Review, Level One Appeal, and Level Two Appeal. Your request for an Expedited or Standard External Independent Review should be submitted in writing.

2. Deadlines Applicable to the Standard External Independent Review Process

   After receiving written notice from CG that your Level Two Appeal has been denied, you have 30 calendar days to submit a written request to CG for External Independent Review. Your request must include any

material justification or documentation to support your request for the service or payment of a claim.

- Medical Necessity Issues

  These are cases where we have decided not to authorize a service because we think the services you (or your treating provider) are asking for, are not medically necessary to treat your problem. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization ("IRO"), that is procured by the Arizona Insurance Department, and not connected with our company. The IRO provider must be a provider who typically manages the condition under review. If your appeal for External Independent Review involves an issue of medical necessity:

- Within five working days of receipt of your request for External Independent Review, CG will:
  - mail a written notice to you, your PCP or treating provider, and the Director of the Arizona Department of Insurance ("Director of Insurance") of your request for External Independent Review, and
  - Send the Director of Insurance: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

GM6000 APL593

External Independent Review

- Within five days of receiving our information, the Insurance Director must send all submitted information to an external independent review organization (the "IRO").
- Within 21 days of receiving the information the IRO must make a decision and send the decision to the Insurance Director.
- Within five working days of receiving the IRO's decision, The Insurance Director must mail a notice of the decision to us, you, and your treating provider. If the IRO decides that CG should provide the service or pay the claim, CG must then authorize the service or pay the claim. If the IRO agrees with CG's decision to deny the service or payment, the appeal is over. Your only further option is to pursue your claim in Superior Court.
- Coverage Issues

  These are cases where we have denied coverage because we believe the requested service is not covered under your certificate of coverage. For contract coverage cases, the Arizona Insurance Department is the independent reviewer. If your appeal for External Independent Review involves an issue of service of benefits coverage or a denied claim:

- Within five working days of receipt of your request for External Independent Review, CG will:
  - mail a written notice to you, your PCP or treating provider, and the Director of Insurance of your request for External Independent Review, and
  - send the Director of Insurance: your request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and any clinical reasons for our decision; and the relevant portions of our utilization review guidelines.
- Within 15 working days of the Director's receipt of your request for External Independent Review from CG, the Director of Insurance will:
  - determine whether the service or claim is covered, and
  - mail the decision to CG. If the Director decides that we should provide the service or pay the claim, we must do so.

GM6000 APL594

External Independent Review

- If the Director of Insurance is unable to determine an issue of coverage, the Director will forward your case to an IRO. The IRO will have 21 days to make a decision and send it to the Insurance Director. The Insurance Director will have five working days after receiving the IRO's decision to send the decision to us, you, and your treating provider.
- CG will provide any covered service or pay any covered claim determined to be medically necessary by the independent reviewer(s) and provide any service or pay any claim determined to be covered by the Director of Insurance regardless of whether CG elects to seek judicial review of the decision made through the External Independent Review Process.
- If you disagree with the Insurance Director's final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If CG disagrees with the Insurance Director's final decision, CG may also request a hearing before the OAH. A hearing must be requested within 30 calendar days of receiving the Insurance Director's decision.

3. Deadlines Applicable to the Expedited External Independent Review Process

After receiving written notice from CG that your Expedited Level Two Appeal has been denied, you have only five business days to submit a written request to CG for an Expedited External Independent Review. Your request must include any material justification or documentation to support your request for the service or payment of a claim.

- Medical Necessity Issues

  If your appeal for Expedited External Independent Review involves an issue of medical necessity:

- Within one working day of receipt of your request for an Expedited External Independent Review, CG will:
  - mail a written acknowledgment to you, your PCP or treating provider, and the Director of your request for Expedited External Independent Review, and

GM6000 APL595

External Independent Review

- forward to the Director your request for Expedited External Independent Review, the terms of the agreement in your contract, all medical records and supporting documentation used to render the adverse decision, a summary description of the applicable issues including a statement of CG's decision, the criteria used and the clinical reasons for the decision, relevant portions of CG's utilization review plan and the name and the credentials of the licensed health care provider who reviewed the case.
- Within two working days after the Director receives the information outlined above, the Director will choose an independent review organization (IRO) and forward to the organization all of the information received by the Director.
- Within five working days of receiving a case for Expedited External Independent Review from the Director, the IRO will evaluate and analyze the case and based on all the information received, render a decision and send the decision to the Director. Within one working day after receiving a notice of the decision from the IRO, the Director will mail a notice of the decision to you, your PCP or treating provider, and CG.
- Coverage Issues

  If your appeal for Expedited External Independent Review involves a contract coverage issue:

- Within one working day of receipt of your request for an Expedited External Independent Review, CG will:
  - mail a written acknowledgment to you, your PCP or treating provider, and the Director of your request for Expedited External Independent Review, and

GM6000 APL629

External Independent Review

- forward to the Director your request for an Expedited External Independent Review, the terms of the agreement in your contract, all medical records and supporting documentation used to render the adverse decision, a summary description of the applicable issues including a statement of CG's decision, the criteria used and the clinical reasons for the decision, relevant portions of CG's utilization review plan and the name and the credentials of the licensed health care provider who reviewed the case.
- Within two working days after receipt of all the information outlined above, the Director will determine if the service or claim is covered and mail a notice of the determination to you, your PCP or treating provider, and CG.
- If the Director of Insurance is unable to determine an issue of coverage, the Director will forward your case to an IRO. The IRO will have five working days to make a decision and send it to the Director. The Director will have one working day after receiving the IRO's decision to send the decision to CG, you and your treating provider.
- CG will provide any covered service or pay any covered claim determined to be medically necessary by the independent reviewer(s) and provide any service or pay any claim determined to be covered by the Director regardless of whether CG elects to seek judicial review of the decision made through the External Independent Review Process.
- If you disagree with the Insurance Director's final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If CG disagrees with the Director's final decision, CG may also request a hearing before OAH. A hearing must be requested within 30 days of receiving the Director's decision.

The Independent Review Program is a voluntary program arranged by CG.

GM6000 APL630

External Independent Review

Under Arizona law, if you intend to file suit regarding a denial of benefit claim or services you believe are medically necessary, you are required to provide written notice to CG at least 30 days before filing the suit stating your intention to file suit and the basis of your suit. You must include in your notice the following:

Member Name....
Member Identification Number
Member Date of Birth
Basis of Suit (reasons, facts, date(s) of treatment or request)

Notice will be considered provided by you on the date received by CG. The notice of intent to file suit must be sent to CG via Certified Mail Return Receipt Request to the following address:

Attention: HealthCare Litigation Unit W-26
Notice of Intent to File Suit
Connecticut General Life Insurance Company
900 Cottage Grove Road
Hartford, CT 06152

Receipt of Documents

Any written notice, acknowledgment, request, decision or other written documents required to be mailed during the process is deemed received by the person to whom the document is properly addressed on the fifth working day after being mailed. "Properly addressed" means your last known address.

Complaints to the Arizona Department of Insurance

The Director of the Arizona Department of Insurance is required by law to require any Member who files a complaint with the Arizona Department of Insurance relating to an adverse decision to first pursue the review process established by the Arizona Legislature and CG as described above.

GM6000 APL631

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (4) a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record, or other information which (a) was relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against CG until you have completed the Level-One and Level-Two Appeal processes. If your Appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action.

GM6000 APL596

Definitions

Active Service

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

DFS1

Bed and Board

The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

DFS14

Charges

The term "charges" means the actual billed charges; except when the provider has contracted directly or indirectly with CG for a different amount.

DFS940

Custodial Services

Any services that are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age or mental or physical condition. This service primarily helps the person in daily living. Custodial care also can provide medical services, given mainly to maintain the person's current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself. Custodial Services include but are not limited to:

- Services related to watching or protecting a person;
- Services related to performing or assisting a person in performing any activities of daily living, such as: (a) walking, (b) grooming, (c) bathing, (d) dressing, (e) getting in or out of bed, (f) toileting, (g) eating, (h) preparing foods, or (i) taking medications that can be self administered, and
- Services not required to be performed by trained or skilled medical or paramedical personnel.

DFS1812

Dependent

Dependents are:

- your lawful spouse; and
- any unmarried child of yours who is
  - less than 19 years old;
  - 19 years but less than 25 years old, enrolled in school as a full-time student and primarily supported by you;
  - 19 or more years old or older and incapable of self-sustaining support by reason of mental retardation or physical handicap which existed prior to attaining 19 years of age. Proof of the child's condition and dependence must be submitted to CG within 31 days after the date the child ceases to qualify above. During the next two years CG may, from time to time, require proof of the continuation of such condition and dependence. After that, CG may require proof no more than once a year;
  - less than 25 years old and on a church mission.

A child includes a legally adopted child, including that child from the first day of placement in your home regardless of whether the adoption has become final. It also includes a stepchild who lives with you.

Benefits for a Dependent child or student will continue until the last day of the calendar month in which the limiting age is reached.

Anyone who is eligible as an Employee will not be considered as a Dependent.

No one may be considered as a Dependent of more than one Employee.

DFS1080 M

Emergency Services/Emergency Medical Condition

Emergency Services are a health care item or service furnished or required to evaluate and treat an Emergency Medical Condition, which may include, but shall not be limited to health care services that are provided in a licensed Hospital's emergency facility by an appropriate provider. An Emergency Medical Condition is the sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:

- Placing the person's health in significant jeopardy;
- Serious impairment to a bodily function;
- Serious dysfunction of any bodily organ or part;
- Inadequately controlled pain; or

- With respect to a pregnant woman who is having contractions:
  - That there is inadequate time to effect a safe transfer to another hospital before delivery; or
  - That transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

DFS1540

Employee

The term Employee means an employee of the Employer who is currently in Active Service.

DFS1940 DFS1940

Employer

The term Employer means the Policyholder and all Affiliated Employers.

DFS212

Expense Incurred

An expense is incurred when the service or the supply for which it is incurred is provided.

DFS60

Free-Standing Surgical Facility

The term Free-standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

DFS682

Hospice Care Program

The term Hospice Care Program means:

- a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
- a program for persons who have a Terminal Illness and for the families of those persons.

DFS70

Hospice Care Services

The term Hospice Care Services means any services provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a Home Health Care Agency, (d) a Hospice Facility, or (e) any other licensed facility or agency under a Hospice Care Program.

DFS599

Hospice Facility

The term Hospice Facility means an institution or part of it which:

- primarily provides care for Terminally Ill patients;
- is accredited by the National Hospice Organization;
- meets standards established by CG; and
- fulfills any licensing requirements of the state or locality in which it operates.

DFS72

Hospital

The term Hospital means:

- an institution licensed as a hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or

- an institution which: (a) specializes in treatment of Mental Health and Substance Abuse or other related illness; (b) provides residential treatment programs; and (c) is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

DFS1693

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- receiving treatment Mental Health and Substance Abuse Services in a Partial Hospitalization program;
- receiving treatment for Substance Abuse Services in a Substance Abuse Residential Treatment Center.

DFS1815

Injury

The term Injury means an accidental bodily injury.

DFS147

Late Entrant

You are a Late Entrant for Employee or Dependent Insurance if:

- you have not been continuously covered for one year under a group medical insurance policy or a self-insured group medical plan, other than a policy issued by a state high risk insurance pool; and
- you have declined medical coverage for yourself or your Dependents through your Employer during the initial enrollment period, or have ended your coverage at any time; and
- you later request coverage for yourself or your Dependents.

The initial enrollment period must have been at least 31 days. An individual is not considered a Late Entrant if one of the following applies:

1. The person, at the time of the initial enrollment period, was covered under a prior plan. "Prior plan" means a public or private group medical insurance policy or self-insured group medical plan.
2. The person lost coverage under the prior plan due to the Employee's termination of employment or eligibility, the termination of the prior plan's coverage, legal separation, the death of the spouse, or divorce.
3. The person's continuation coverage has been exhausted and the Employee requests enrollment within 31 days after exhausting prior coverage.
4. The person requests enrollment within 31 days after the termination of coverage provided under the prior plan.
5. The person is employed by an Employer that offers multiple medical plans and the person elects a different plan during an open enrollment period.
6. A court orders that coverage be provided for a spouse or minor child under a covered Employee's medical plan and the Employee requests enrollment within 31 days after the court order is issued.
7. You acquire a new Dependent through marriage, birth, adoption or placement for adoption and the Employee requests enrollment within 31 days of such event.

"Continuously covered" means the person is covered at the beginning and the end of the period and has not had any breaks in coverage during the period totaling more than 63 days.

DFS1941

Maximum Reimbursable Charge

The Maximum Reimbursable Charge is the lesser of:

- the provider's normal charge for a similar service or supply; or

- the policyholder-selected percentile of all charges made by providers of such service or supply in the geographic area where it is received.

To determine if a charge exceeds the Maximum Reimbursable Charge, the nature and severity of the Injury or Sickness may be considered.

CG uses the Ingenix Prevailing Health Care System database to determine the charges made by providers in an area. The database is updated semiannually.

The policyholder-selected percentile used to determine the Maximum Reimbursable Charge can be obtained by contacting Member Services/Customer Service.

Additional information about the Maximum Reimbursable Charge is available upon request.

GM6000 DFS1814

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

DFS192

Medically Necessary/Medical Necessity

Medically Necessary Covered Services and Supplies are those determined by the Medical Director to be:

- required to diagnose or treat an illness, injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or other health care provider; and
- rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.

DFS1813

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

DFS149

Necessary Services and Supplies

The term Necessary Services and Supplies includes:

- any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement;
- any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and
- any charges, by whomever made, for the administration of anesthetics during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

DFS151

Nurse

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

DFS155

Other Health Care Facility

The term Other Health Care Facility means a facility other than a Hospital or hospice facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities.

DFS1686

Other Health Professional

The term Other Health Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses.

DFS1685

Participating Provider

The term Participating Provider means a hospital, a Physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with CIGNA to provide covered services with regard to a particular plan under which the participant is covered.

DFS1910

Physician

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

DFS164

Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Psychologist.

DFS170

Review Organization

The term Review Organization refers to an affiliate of CG or another entity to which CG has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance abuse professionals, and other trained staff members who perform utilization review services.

DFS1688

Sickness – For Medical Insurance

The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

DFS531

Skilled Nursing Facility

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: (a) maintains on the premises all facilities necessary for medical treatment; (b) provides such treatment, for compensation, under the supervision of Physicians; and (c) provides Nurses' services.

DFS193

Terminal Illness

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

DFS197

Urgent Care

Urgent Care is medical, surgical, Hospital and related health care service and testing which is provided to treat a condition that is: (1) less severe than an Emergency Medical Condition; (2) requires immediate medical attention; and (3) is unforeseen. Care which could have been foreseen as needed before leaving the provider network area where the insured ordinarily receives and/or was scheduled to receive services does not meet the definition of Urgent Care. Such foreseeable care includes, but is not limited to, delivery beyond the 35th week of pregnancy, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.

DFS1541

Participating Pharmacy

The term Participating Pharmacy means a retail pharmacy with which Connecticut General Life Insurance Company has contracted to provide prescription services to insureds; or a designated mail-order pharmacy with which CG has contracted to provide mail-order prescription services to insureds.

DFS1937

Pharmacy

The term Pharmacy means a retail pharmacy, or a mail-order pharmacy.

DFS1934

Pharmacy & Therapeutics (P & T) Committee

A committee of CG Participating Providers, Medical Directors and Pharmacy Directors which regularly reviews Prescription Drugs and Related Supplies for safety and efficacy. The P&T Committee evaluates Prescription Drugs and Related Supplies for potential addition to or deletion from the Prescription Drug List and may also set dosage and/or dispensing limits on Prescription Drugs and Related Supplies.

DFS1919

Prescription Drug List

Prescription Drug List means a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the P&T Committee. The Prescription Drug List is regularly reviewed and updated.

DFS1924

Prescription Drug

Prescription Drug means; (a) a drug which has been approved by the Food and Drug Administration for safety and efficacy; (b) certain drugs approved under the Drug Efficacy Study Implementation review; or (c) drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

DFS1708

Prescription Order

Prescription Order means the lawful authorization for a Prescription Drug or Related Supply by a Physician who is duly licensed to make such authorization within the course of such Physician's professional practice or each authorized refill thereof.

DFS1711

Related Supplies

Related Supplies means diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for injectables covered under the pharmacy plan, and spacers for use with oral inhalers.

DFS1710

The following pages describe the features of your CIGNA Choice Fund - Health Savings Account . Please read them carefully.

What You Should Know about CIGNA Choice Fund℠ — Health Savings Account

CIGNA Choice Fund is designed to give you more of what you want:

- Options to help you manage your health *and* your health care
- Simple ways to predict and track cost
- A better understanding of your options

What's in it for you?

Control

The services you get and where you get them are up to you.

Choice

You have the freedom to choose any licensed doctor, **even those who do not participate with** CIGNA HealthCare. Your costs are lower for services from CIGNA contracted providers.

***You** Manage Your Health Savings Account*

You decide how much you'd like to contribute (up to federal limits). You decide how and when to access the account. And the money in the account is yours until you spend it. Unused dollars remain in your account from year to year and earn interest.

Flexibility and Tax Savings

You can choose to pay for medical expenses out of your pocket until you reach the deductible, allowing you to save for qualified medical expenses in future years or retirement. You are not taxed on your HSA unless you use the money to pay for non-qualified expenses.

Easy Access to your HSA Dollars

You can draw money directly from your health savings account using the JPMorgan Chase/MasterCard® debit card or checkbook. Or, you may choose automatic claim forwarding, which allows CIGNA to pay your qualified medical claims directly from your account to your doctor or hospital.

Tools

Easy-to-use resources help you make informed decisions.

Health Information and Education

Call the toll-free number on your ID card to reach the CIGNA HealthCare 24-Hour Health Information Line, giving you access to registered nurses and an audio library of health topics 24 hours a day. In addition, the CIGNA HealthCare Healthy Babies program provides prenatal education and support for mothers-to-be.

Support

We help you keep track with online benefits information, transactions, and account activity; medical and drug cost comparisons; quarterly statements; and more. You also have toll-free access to dedicated Member Service teams, specially trained to answer your questions and address your needs.

Savings on Health and Wellness Products and Services

Through CIGNA Healthy Rewards®, you can save money on products and services not often covered by many traditional plans. Offerings include laser vision correction, acupuncture, chiropractic care, Weight Watchers®, and more.

Who is eligible?

You are eligible to open a Health Savings Account only if you are covered under a federally qualified high deductible health plan, such as the one described in this booklet. However, you cannot be covered by Medicare or any other individual or group health plan that is not a federally qualified high deductible health plan. You can no longer contribute to the HSA once you: become entitled to Medicare due to age; or are no longer covered under a high deductible health plan. However, you will still be able to use the HSA funds for qualified medical expenses.

How does it work?

The Health Savings Account combines traditional medical coverage with a savings account.

1. **You and your employer may contribute**. Contributions are tax-free up to federal limits.
2. **You choose how to pay for qualified medical expenses:**

- You may pay claims on your own using a debit card or checkbook that draws from your savings account.
- You may choose the Automatic Claim Forwarding option, allowing claims to be paid directly to your doctor, hospital, or other facility. So you don't have to do a thing – your claims are paid automatically while there is money in your savings account. (You can change your election at any time during the year.)
- You may choose to cover your expenses using your own personal funds. This allows you to save your HSA dollars for qualified medical expenses in future years or at retirement. The balance in your savings account will earn interest.

Regardless of how you choose to pay for qualified medical expenses, the next step is to meet the deductible. Only covered services count toward the deductible.

3. **Once your deductible is met, you use a traditional medical plan for covered services.** Depending on your plan, you pay pre-determined coinsurance or copayments for certain services. Your employer determines the maximum amount of out-of-pocket

expenses you pay each year.

Which services are covered by my CIGNA Choice Fund Health Savings Account?

HSA funds can be used to cover only qualified medical expenses for you and your dependents as allowed under federal tax law. In addition, HSA funds can be used to cover COBRA continuation premiums, qualified long-term care insurance premiums, health plan premiums when you are receiving unemployment compensation, or Medicare or retiree health plan premiums (excluding Medicare Supplement or Medigap premiums) once you reach age 65. If you use your HSA funds for expenses that not allowed under federal tax law, the contributions to your HSA fund and any accrued interest and earnings will be subject to tax, and you will incur a 10 percent tax penalty. The 10 percent penalty is not applicable once you reach age 65. A list of qualified medical expenses is available on myCIGNA.com.

Which services are covered by my CIGNA medical plan, and which will I have to pay out of my own pocket?

Covered services vary depending on your plan, so visit myCIGNA.com or check your plan materials in this booklet for specific information. In addition to your monthly premiums deducted from your paycheck, you'll be responsible for paying:

- Any health care services not covered by your plan.
- Costs for any services up to your deductible, if you choose not to use your savings account, or after you spend all the money in your account.
- Your coinsurance or copayments after you meet the deductible and your medical plan coverage begins.

If all of your medical expenses are covered services and the total cost doesn't exceed the amount in your savings account, you won't have additional out-of-pocket costs.

Your plan may also include a Flexible Spending Account (FSA). If you are eligible to enroll in this account, you can contribute pre-tax dollars from each paycheck — then use the funds to reimburse yourself for qualified medical expenses. Before you meet your medical plan deductible, FSAs can be used only for qualified dental, vision and prescription drug expenses, if your employer allows. After you meet the medical plan deductible, the FSA can reimburse qualified medical expenses as well as other over-the-counter pharmacy, vision and other expenses as determined by your employer.

Are services covered if I use out-of-network doctors?

You can use the dollars in your HSA to visit any licensed doctor or facility. However, if you choose a provider who participates with CIGNA HealthCare, your costs will be lower.

Key Terms

Deductible

The amount that you must pay for covered medical expenses before the underlying health plan covers expenses

Collective Deductible

If you have family coverage, you must pay all costs up to the family deductible before you use the medical plan for covered ser-vices, even if qualified expenses for one person meet your plan's individual deductible.

For example: Suppose your plan has an individual deductible of $1,000 and a family deductible of $2,000. If you pay $1,000 in qualified medical expenses for one person, you still do not meet your deductible until qualified costs from any individual or all covered persons total $2,000.

Maximum Savings Account Amount

The maximum amount of money you may have in your HSA

Plan Coinsurance

The percentage of charges you pay for expenses covered by your traditional medical plan.

Tools and Resources at Your Fingertips

Online

Visit **myCIGNA.com**, our personalized, secure web site, to better understand CIGNA Choice Fund and make informed decisions on doctors, hospitals, prescription medicines, and your health and well-being.

- Look up your current fund balance, past transactions and claim status.
- Track your account balance and estimate your out-of-pocket expenses.
- Compare average medical and drug costs by location and pharmacy.
- Learn about other CIGNA HealthCare products and services — what they are and how you can use them.
- Find answers to frequently asked questions – about health care in general and CIGNA HealthCare specifically.
- Take advantage of a number of convenient, helpful tools:

  Pharmacy Tools

  Find out what you'll pay for prescriptions, compare characteristics of medications, and view your claims history.

  Select Quality Care™ Hospital Comparison Tool

  Find out how hospitals rank by number of procedures performed, patients' average length of stay, and cost. Get information on more than 170 surgical and medical

procedures through a personalized report. You can also use the provider directory to find "Centers of Excellence," which includes hospital scores for specific procedures/conditions.

HealthQuotient™ Health Risk Assessment

Take an online questionnaire that can help you identify and monitor your health status. You also can find out how your family health history may affect you, learn about preventive care, get recommendations to enhance your health and well-being based on your health profile, and check your progress toward healthy goals.

Healthwise®

Find medical content on more than 5,000 health conditions, health and wellness, first aid and medical exams.

Health Record

Record and store personal health information in a central, secure location. Include current conditions, medications, allergies, surgeries, immunizations and emergency contacts. Health Record includes HealthQuotient health risk assessment results, which you can easily print and share with your doctor.

Health Tracker

Track your progress on key health indicators, such as blood pressure, blood sugar, cholesterol, fitness, height and weight. You can display results in charts, edit past data easily, and share information with your doctor.

On the Phone

Call the toll-free number on your CIGNA HealthCare ID card to reach the CIGNA HealthCare 24-Hour Health Information Line℠. You can speak to a registered nurse for guidance on appropriate care or directions to the nearest facility. You also can listen to audio tapes on a variety of health topics. It's easy, reassuring, convenient and confidential.

Getting the Most from Your HSA

As a consumer, you make decisions every day – from buying the family car to choosing the breakfast cereal. Make yourself a more educated health care consumer and you'll find that you, too, can make a difference in the health care services you receive and what you ultimately pay.

Fast Facts

If you visit a CIGNA HealthCare participating provider, the cost is based on discounted rates, so your costs will be lower.

If you visit a provider not in the network, you may still use CIGNA Choice Fund to pay for the cost of those services, but typically you will pay a higher rate, and you may have to file claims.

If you need hospital care, there are several tools to help you make informed decisions about quality and cost.

- With the Select Quality Care™ hospital comparison tool on myCIGNA.com, you can learn how hospitals rank by number of procedures performed, patients' average length of stay, and cost.
- Visit our provider directory for CIGNA "Centers of Excellence," providing hospital scores for specific procedures/conditions, such as cardiac care, hip and knee replacement, and bariatric surgery. Scores are based on cost and effectiveness in treating the procedure/condition, based on publicly available data.
- www.cigna.com also includes a Provider Excellence Recognition Directory. This directory includes information on:
  - Participating physicians who have achieved recognition from the National Committee for Quality Assurance (NCQA) for diabetes and/or heart and stroke care.
  - Hospitals that fully meet The Leapfrog Group patient safety standards.

Wherever you go in the U.S., you take the CIGNA HealthCare 24-Hour Health Information Line℠ with you.

Whether it's late at night, and your child has a fever, or you're traveling and you're not sure where to get care, or you don't feel well and you're unsure about the symptoms, you can call the CIGNA HealthCare 24-Hour Health Information Line whenever you have a question. Call the toll-free number on your CIGNA HealthCare ID card and you will speak to a nurse who will help direct you to the appropriate care.

A little knowledge goes a long way.

Getting the facts about your care, such as treatment options and health risks is important to your health and well-being – and your pocketbook. For instance:

- Getting appropriate preventive care is key to staying healthy. Your CIGNA HealthCare participating doctor can provide a wide variety of tests and exams that are covered by your CIGNA HealthCare plan. Visit myCIGNA.com to learn more about proper preventive care and what's covered under your plan. You can also find ways to stay healthy by calling the CIGNA HealthCare 24-Hour Health Information Line, which includes audio tapes on preventive health, exercise and fitness, nutrition and weight control, and more.
- When it comes to medications, talk to your doctor about whether generic drugs are right for you. The brand name drugs you are prescribed may have generic alternatives that could lower your costs. If a generic version of your brand name drug is not available, other generic drugs with the same treatment effect may meet your needs.
- The health care cost estimator tool on myCIGNA.com can help you use the plan effectively. When planning and

budgeting, consider:

- Your medical and prescription drug expenses from last year.
- Any expected changes in your medical spending in the coming year.
- Your anticipated benefit expenses and out-of-pocket costs for the coming year.
- The amount in your CIGNA Choice Fund compared with your expected out-of-pocket costs. Keep in mind the copayment and/or coinsurance you will pay once the fund is spent.

- Additional tools on myCIGNA.com can help you take control of your health, learn more about medical topics and wellness, and keep track of your personal health information. You can print personalized reports to discuss with your doctor.

Your HSA can be a tax-sheltered savings tool. Because your HSA rolls over year after year, and unused money accumulates tax-deferred interest, you have the option to pay for current qualified medical expenses out of your pocket and use the account to save for future qualified medical expenses.

Please note: Your HSA contributions are not taxable under federal and most state laws. However, your contributions to your HSA may be taxable as income in the following states: Alabama, California, Iowa, Maine, Massachusetts, Minnesota, New Jersey, Pennsylvania, and Wisconsin. If you live or work in one of these states, please consult your tax advisor.

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